



ARMY MEDICINE

2020

CAMPAIGN PLAN

43RD SURGEON GENERAL, UNITED STATES ARMY



Serving To Heal...Honored To Serve

Version 2 (20130304)

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The Army Medicine 2020 Campaign Plan operationalizes our vision and strategic imperatives to ensure that the Army leads the Nation in health. This campaign plan will allow us to create the capacity required to promote individual, unit and organizational health, as well as continue our core mission: to enhance diplomacy by building new partnerships and strengthening old ones; to promote unity of effort at all levels; and improve individual and organizational stamina to enable unit effectiveness – a must for readiness and integral in successfully achieving the Army’s role to Prevent, Shape and Win the Nation’s wars.

This plan uses three Lines of Effort (LOE) - Increase Capacity, Enhance Diplomacy and Improve Stamina - to achieve our end state. Army Medicine will track progress along these LOE, using clear, outcome-based metrics, which will allow us to plan, prepare, execute and assess action. The Army Medicine 2020 Campaign Plan is synchronized with the Army’s Ready and Resilient Campaign Plan, a strategic effort of the Army Campaign Plan. The AMEDD 2020 Campaign Plan focuses on outcomes - to improve readiness, save lives and advance health in support of the Total Force.

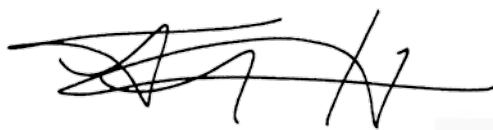
Our experience and collective success in advancing medicine over the past 11 years strengthens our capacity, commitment, and resolve to be a national leader in health. Army Medicine is America’s premier medical team, and our accomplishments in saving lives on the battlefield and taking care of Soldiers and Families demonstrate our phenomenal resilience, dedication, and agility. Our actions serve as a world-class example for our international partners.

Our success, and indeed our legacy, will be measured by how well we meet the challenges before us. This Campaign Plan provides the road map that will help guide Army Medicine to 2020 and beyond.

Serving to Heal...Honored to Serve!



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Introduction

a. Purpose

The Army Medicine 2020 Campaign Plan (AM 2020 CP) operationalizes the vision of the Commanding General, United States Army Medical Command (MEDCOM) for 2020. It also establishes the framework through which the Army Medical Department (AMEDD) will achieve its 2020 end state and ensure its forces remain ready to meet current and emerging Medical Support requirements to Combatant Commanders and CONUS Sustaining Bases. The AM 2020 CP provides the Commanding General's broad communication guidance and the context necessary to progress toward the 2020 end state.

b. Scope

In addition to providing long-term guidance through calendar year 2020, this document describes strategic and operational objectives to guide and synchronize near- and mid-term efforts.

The AM 2020 CP will be updated annually (or as required) to ensure relevance and synchronization with the Army Campaign Plan. The AM 2020 CP pertains to all Soldiers and Civilians under the administrative control (ADCON) of Army Medicine and informs the commands and agencies that support Army Medicine and Army Medical Support process. The operational aspect and the assessment process is managed through the AMEDD portal at <https://mitc.amedd.army.mil/sites/Communities/CampaignPlan/Pages/default.aspx>

c. Mission

Army Medicine provides responsive and reliable health services and influences Health to improve readiness, save lives and advance wellness in support of the Force, Military Families and all those entrusted to our care.

d. Vision

Strengthening the health of our Nation by improving the health of our Army.

e. Key Tasks

- Create a System For Health
- Influence the Lifespace
- Promote healthy lifestyles and behaviors
- Provide a Consistent Patient Experience
- Strengthen Partnerships and Relationships
- Establish Operating Company Methodology
- Establish Metrics for Health
- Model Healthy Lifestyles
- Transform Reimbursement System
- Change the Conversation from healthcare to health
- Enable Active Communities

f. Commander's Intent

Transform from a healthcare system to a **System For Health**. The System For Health will maintain, restore and improve the health, readiness and resilience of Soldiers, Families and Communities in order to enable the Army to Prevent, Shape and Win the nation's wars.

g. End State

Near-Term: A unity of effort defined with validated priorities and optimized AMEDD footprint within an operating company framework.

Mid-Term: Codified and validated prioritized initiatives that support a System For Health.

Long-Term: System For Health produces validated outcomes that improve Health.

Campaign Plan Endstate: A System For Health that enables Ready and Resilient Soldiers, Families and Communities in order to Prevent, Shape and Win.





Strategic Environment and Risk

a. Strategic Health Environment

In the last decade there have been dramatic technological advancements leading to real health improvements across the globe. Interdependence, rapidly improving connectivity and technological and medical innovation have all created extraordinary new opportunities to improve health care and health outcomes. The technological capability available to understand, prevent, diagnose and treat disease has been transformed in an almost exponential progression. Diagnostic, medical and surgical interventions have expanded dramatically, as has drug-based therapy. E-health and telemedicine are examples of the transformative effects of new information technology (World Health Organization, Health 2020).

Furthermore, while health care has traditionally operated as a profit and cost-dominated industry, recent legislative actions, including the Patient Protection and Affordable Care Act, reflect a growing public consensus that the health of populations is critical for social stability, social cohesion and economic growth.

Health systems, including the role of health care providers and patients, are also shifting fundamentally as chronic diseases become the largest cause of death and disability worldwide. According to the WHO, the proportion of the burden of non-communicable disease worldwide is expected to increase to 57% by 2020. Almost half of chronic disease deaths are attributable to cardiovascular disease, obesity, and diabetes –which are appearing in individuals earlier in life. Chronic diseases necessitate a strategy that clearly defines people's roles and responsibilities in managing health both in concert with providers and in the Lifespace.

Within the Department of Defense (DoD), healthcare is also experiencing dramatic transformation. Technological and medical advancements, coupled with revised strategy and training across the Services, have improved health outcomes to unprecedented levels, both in-theater and at home. Increased interoperability and the implementation of the 2005 Base Realignment and Closure (BRAC) requirements have further altered the military health care delivery environment. Additionally, increases in both beneficiaries and health benefits in military medicine continue to strain budgets, challenging the Military Health System to provide top-tier medical support for military operations, while simultaneously instituting cost containing measures. These dual imperatives continue to drive strategy and military health transformation toward a collaborative shared services structure.

b. Transformation and Change

To remain relevant in the quickly changing environment, Army Medicine must be proactive and create a near, mid and long term (2020) road map to help the organization transform to meet new challenges and demands, while simultaneously maintaining the current global mission. There is the fundamental need to improve readiness in the context of health, resilience and performance. To strengthen the readiness and performance of Soldiers, Army Medicine must optimize health and resilience by improving the quality of activity, nutrition and sleep.

Collectively, these three components—Activity, Nutrition and Sleep—are known as the Performance Triad. Getting back to the basics of Activity, Nutrition and Sleep, as both leaders and healthcare providers, will be key in optimizing individual and unit performance and readiness. The strength of the Army is its Soldiers, and Army Medicine plays a key role in optimizing that professional Soldier's performance and resilience through health.

To move from a healthcare system to a System For Health, Army Medicine must impact the determinants of health – those lifestyle choices and social and environmental factors that contribute to the overall health – which



are at the heart of the Lifespace. The foundations of Army Medicine's success to create capacity, enhance diplomacy, improve stamina, and ultimately transform to a System For Health, rest within the Performance Triad.

The Army 2020 Campaign plan, supported by the operating company (OC) framework, is the deliberate method by which Army Medicine will impact the System For Health. The OC is designed around integrated, standard processes across the organization; performance metrics and decision-making that are clearly defined for these processes, thereby driving accountability; and a high focus and priority given to process quality, repeatability and standards to drive a more consistent patient experience while also containing costs.

c. Army Medicine

As a Generating Force, Army Medicine provides Army Forces support through the provision of trained and ready medical personnel. Army Medicine's 82,405 Active Component Soldiers, 93,725 Army Civilians and 160,679 United States Army Reserve Soldiers form a powerful medical team determined to keep Army Forces ready, fit and healthy.

Army Medical Command (MEDCOM), the second largest Army Command, is headquartered at Joint Base San Antonio, Texas. The Office of the Surgeon General (OTSG), a staff proponent to Headquarters Department of the Army, is located at the Pentagon and the Defense Health Headquarters (DHHQ) at Falls Church, Virginia. Combined, MEDCOM and OTSG form the ONESTAFF.

Army Medicine must always remain ready to support Army Decisive Action and is responsible for providing ready medical personnel to meet Combatant Commander and Service requirements. Supported units include task organized, Combat Support Hospitals (CSH) and Forward Surgical Teams (FST) in Joint Task Force (JTF), Corps and Divisions, and Brigades.

Army Medicine must apply the lessons learned from operating in a Joint, Interagency, Intergovernmental and Multinational (JIIM) environment. Army Medicine must also apply the lessons as we plan and prepare for an Operational Environment which will include joint health governance.

The environment after the year 2015 remains uncertain; however, the global interests and responsibilities of the United States will endure. There is no indication that the hybrid threat to those interests will diminish. Our



land forces must be prepared to operate and win given a wider array of joint operations, in any part of the world, alongside multinational force.

Army Medicine must also account for new and emerging threats in the Operational Environment. As asymmetric approaches and capabilities increase, computer network operations and cyber attacks on U.S. military communications are possible. Army Medicine will support the Army's regionally aligned and tailored forces to each Geographic Combatant Commander leading to successful operations with our JIIM partners. Supported forces will include Medical Commands (Deployment Support), Medical Brigades and Multifunctional Medical Battalions.

Given the current and anticipated Operational Environment described, it is imperative that we focus our effort to sustain and build capabilities to prevent future conflicts and shape the strategic environment for stability. Should this approach fail, we must sustain trained and ready versatile medical forces - forces that enable decisive action.

We cannot accomplish this without a total force approach that includes a sustainable force mix of Active and Reserve Medical Support Component capabilities tailored to accomplish all assigned missions.

d. Risk

Army Medicine's ability to meet unforeseen challenges now and in the future is dependent upon its ability to adapt in structure and balance current and future demands. Identifying and managing risk is essential to Army Medicine's success in supporting regionally aligned forces. Army Medicine must address short-term budgetary challenges facing both the MEDCOM and the Army while supporting the current fight, achieving the proper balance between current and future demands, and addressing long-term threats.





Key Concepts

a. System for Health (SFH)

...is a partnership among Soldiers, Families, Leaders, Health Teams and Communities to promote **Readiness, Resilience and Responsibility.**

- ✓ **MAINTAINS** health through fitness and illness/injury prevention
- ✓ **RESTORES** health through patient centered care
- ✓ **IMPROVES** health through informed choices in the Lifespace



b. Lifespace

About one-third of life is spent working, another third with Family and friends and another third sleeping. Providers see patients on average about 100 minutes out of one year (525,600 minutes). Health occurs in the Lifespace, or in other words, the 525,500 minutes spent away from the doctor's office. A person's Lifespace can be shaped by making wise choices.

Within the environment where Soldiers and Families live and work are the Lifespaces and influences on health, including finances, commissary, fitness center, work environment, Family, friends and community.

Army Medicine's sphere of influence is currently in the realm of Health Care Services. These traditional portals which influence health include clinic visits, inpatient stays and rehabilitation. In the near future, portals or touch points will extend from traditional brick and mortar facilities to the Lifespace of Soldiers, Family Members and our Retirees.

c. Maintain, Restore and Improve Health

Maintain Health: This describes daily efforts across Army Medicine which help our Soldiers and their Families maintain health. It happens in Table of Organizational and Equipment (TOE) units and organizations as well as Table of Distribution and Allowances (TDA) units and organizations. Some of "Maintain Health" happens in deployed units, laboratories and research facilities, teaching facilities, medical and dental treatment facilities and garrisons around the world. It also happens, more than anywhere else, in the personal Lifespace of our Soldiers, Families and DA civilians.

Restore Health: This describes our efforts once illness or injury occurs. This is where we actively intervene and treat patients and includes medical, dental and public health. It's also research and teaching modern techniques and materials that speed restoration of health and quality living. But as with "Maintain Health", "Restore Health" happens primarily in the Lifespace of our patients, after they have left our direct care.

Improve Health: This describes our efforts throughout Army Medicine to turn the "Health" dial of our patients in the right direction. To help Soldiers and their Families become better, healthier and stronger (physically, psychologically and spiritually). We want them to be stronger and better prepared to cope when illness, injury or the inevitable stress of life take their toll. As with the other two categories, Improve Health happens in the Lifespace where the behaviors behind real lasting change occur.



d. Performance Triad (Activity, Nutrition, and Sleep)

The Performance Triad, composed of Activity, Nutrition and Sleep (ANS), will be foundational for Army Medicine's transformation to a System For Health. Outreach and intervention programs based upon these three components will identify gaps and bring together a synchronized action plan to restore and improve the Health of the Force for the Army and Army Medicine beneficiaries.

Health for the Army means we have Soldiers who are fit, ready and resilient. For Army Medicine, this means understanding where health happens and the steps we personally must take to influence health.

The Performance Triad Action Plan was developed in collaboration with military and civilian Activity, Nutrition and Sleep experts. It incorporates components of Army Medicine's health programs, including Soldier Centered Medical Home, Patient Centered Medical Home and Warrior Transition Units. Once operational, the Performance Triad Action Plan will enable the Army to better help Soldiers, Families and DA civilians shape their Lifespace for continued good health.

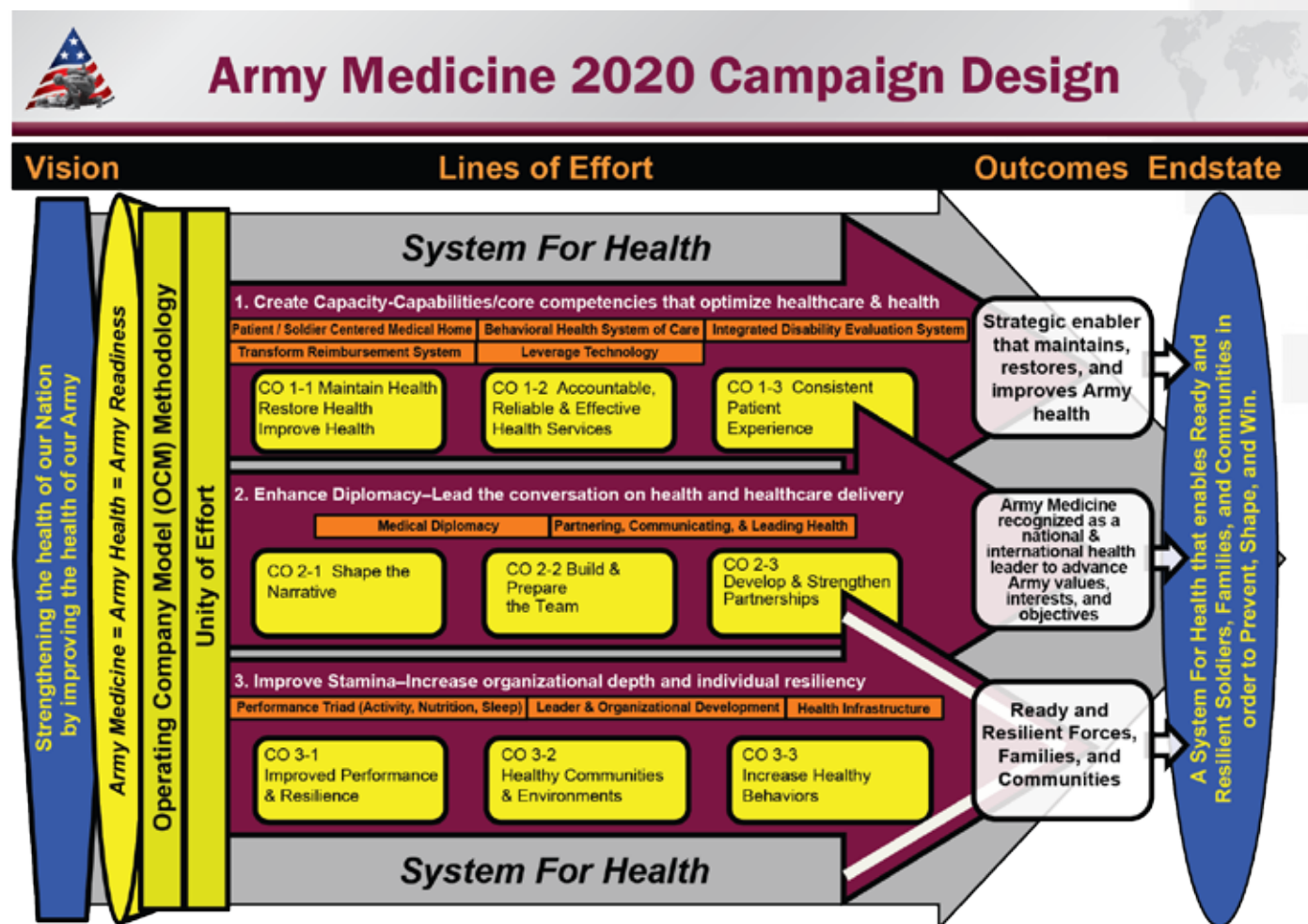
e. Operating Company

The Operating Company (OC) is an organizational methodology that will enable Army Medicine to move toward a System For Health. The OC framework is designed around integrated, standard processes across the organization; performance metrics and decision-making that are clearly defined for these processes, thereby driving accountability; and a high focus and priority given to process quality, repeatability, and standards to drive a better, more consistent patient experience while also containing costs.

The OC framework, with its five critical components, will drive consistency, clarity and accountability across the Lines of Effort (LOEs). The OC translates strategy into operational capabilities, and as a result provides the foundation for execution. These components are:

1. *Process Structure*: Development of repeatable processes with clear standards and owners, and line of sight to integration points. This will answer: How does Army Medicine get things done with high quality?
2. *Organizational Structure*: Creation of an organizational structure that supports the business processes and outlines roles, responsibilities and reporting lines. This will answer: How do we deploy our people in support of our LOEs?
3. *Governance and Decision-making*: Development of a governance structure that clearly delineates decision-making authority and accountability. This will answer: Who makes the call when we have competing priorities?
4. *Performance Metrics and Accountability*: Implementation of a performance management system inclusive of metrics, benefits realization for resource and budget consumption, and a continuous improvement mechanism. This will answer: How well are we performing and communicating results?
5. *Culture*: Allows the organization to embrace an interdependent, transparent and collaborative relationship across Army Medicine functions/services reinforced through a system of accountability. This will answer: How well do we work together to support the LOEs?

Operational Design



Sources include: MHS Strategic Guidance 2012 (Stakeholders Report), Army Strategic Planning Guidance (ASPG) 2012, Army Campaign Plan 2012, Army Ready & Resilient Campaign Plan 2012 (DRAFT), Army Health of the Force (HoF) 2012, Army Medicine – The Road Ahead (v1.B), AMEDD Strategy 2020 White Paper 2012, MHS Conference 2012, OC Documentation 2012, and Escape Fire Discussion 2012

Operational Design - Key Concepts:

- 1) Emulates, nests, and aligns with Army Strategic Planning Guidance (ASPG) Vision and Army Campaign Plan (ACP) end state: Prevent, Shape, Win – Framing What the Army Provides to the Nation
- 2) Provides consistency and aligns with previous published Army Medicine strategy documents and discussion(s).

Description:

- 1) End state
 - AM 2020 CP End state incorporates System For Health, Army Ready & Resilient Campaign Plan, and Army Strategy documents.



2) Outcomes

- Outcomes incorporate AM 2020 Mission and Vision, AMEDD Lines of Effort, as well as MHS Strategic Healthcare to Health Quadruple Aim.

3) Lines of Effort (LOEs) – Grey Arrow and Burgundy Arrows

- System For Health is the underlying and overall line of effort (depicted by the grey arrow) that is supported by the three LOEs that are derived from the strategic imperatives / framework.
- LOE – Improve Stamina is the Main Effort (ME) that focuses on the Performance Triad, Leader and Organizational Development and Health Infrastructure.

4) Campaign Objectives (COs) – Yellow Boxes

- Each of the COs were developed by incorporating AM 2020 Strategy Document tenets, key tasks (derived from the specified and implied tasks), and key concepts from the Army Medicine Campaign Assessment and Performance Dashboard (CAP-D), that support the identified end state(s).

5) Focus Areas – Orange Boxes

- Each of focus areas are specific programs, projects or initiatives that have been identified as a priority pertaining to all COs within the particular LOE. Not all programs, projects or initiatives are considered focus areas.

6) Enablers – Vertical Yellow Oval and Box

- Army Medicine Message is the statement that speaks not only to Army Medicine, but also HQDA, Sister Services, DoD, other agencies, outside organizations and communities, the United States and international entities. Army Medicine Message shapes dialogue towards the 2020 end state.
- OC methodology is the strategic supporting enabler (an actionable business process) which spans the entire AM 2020 strategic effort that defines how well strategy will be executed in the near, mid, and long term future.

Lines of Effort

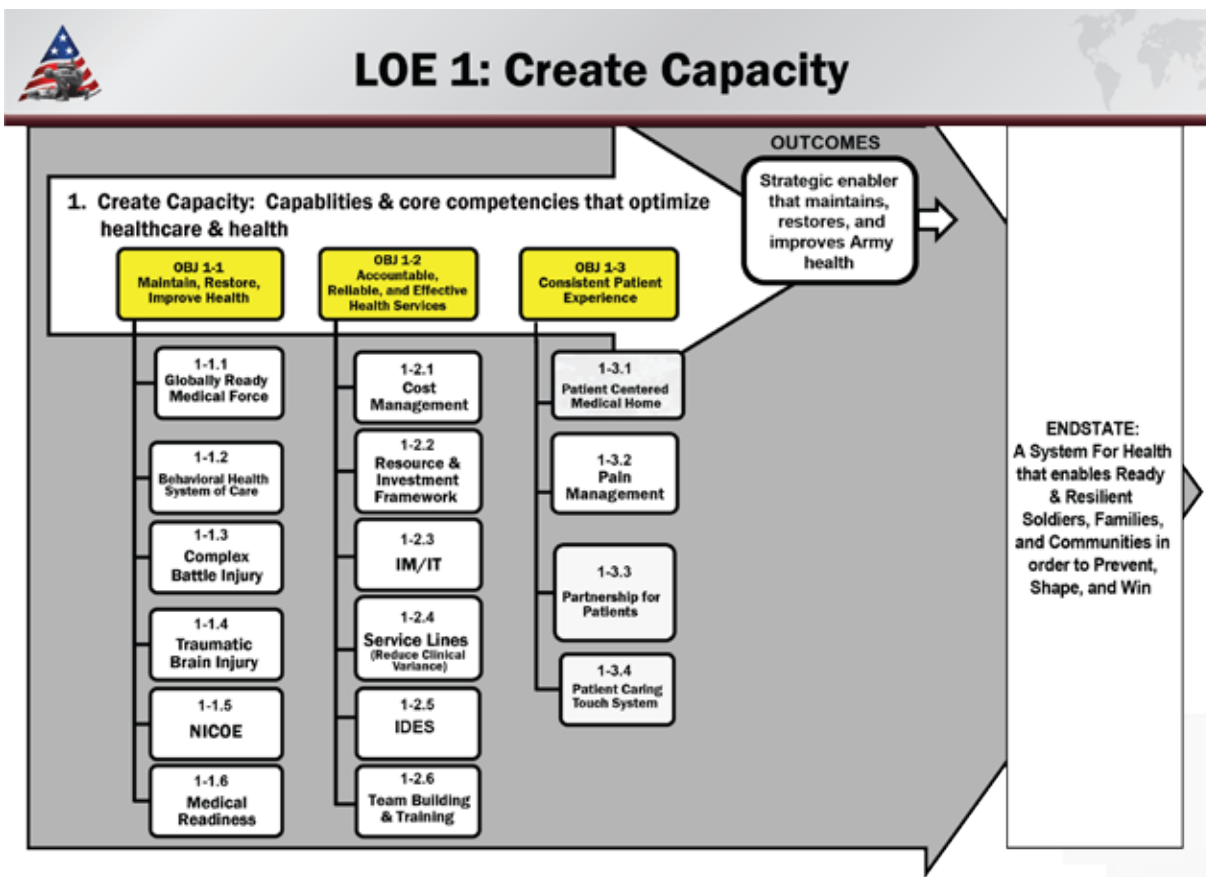
These LOEs are founded in AMEDD's core competencies as well as MEDCOM imperatives which include Soldier and Patient Centered Medical Home, Community Based Medical Home leader development, communication and Mission Command. Progress will be tracked along these LOEs by using campaign objectives, major objectives, critical tasks and measures of performance and effectiveness.

- a. LOE 1: Create Capacity:** Capabilities and core competencies that optimize healthcare and health
- b. LOE 2: Enhance Diplomacy:** Lead the conversation on health and health care delivery
- c. LOE 3: (Main Effort) Improve Stamina:** Increase organizational depth and individual resiliency

a. Strategic Imperative - Create Capacity

From Army Medicine Strategy - The Road Ahead (v2.B as of 29 August 2012)

Our collective ability to develop the capabilities and core competencies necessary to deliver services and programs, which improve healthcare, influence overall health and make Army Medicine a strategic enabler for the Army in the future environment. This includes optimization, innovation, and organizational learning.



Line of Effort (LOE) 1 – Create Capacity

Our dedication to strengthening our Nation through a healthy and ready Army shapes our support from the battlefield to home station. Over the last decade of conflict, Army Medicine has contributed to new and land-



mark processes, training and equipment to produce the best combat survival rates in history. We have a sacred responsibility to our Warfighters and their families to inculcate these lessons and advancements into our doctrine and medical platforms to best meet any future threats. We build our Army through **maintaining, restoring** and **improving** the health of our Soldiers and Families to keep them in our formations through an agile and responsive System For Health. We position our medical forces on the front lines of health promotion and prevention, while sustaining our high performing healthcare delivery system – Army Medicine: capable and competent for challenges in peace and in contingency operations.

Army Medicine creates capacity through patient-centered care and prevention. We have been **maintaining, restoring** and **improving** health for more than two centuries – it is a mandate. We are deliberately investing more of our resources in health and prevention to reduce the need for restorative care and to shape a healthy, ready Army. Creating capacity, by lessening demand for “sick and injured” care, will facilitate better care for Soldiers and Families in their Lifespace. This will lead to increased enrollment, trust and satisfaction.

Army Medicine must innovate. Army Medicine will learn, grow and build strong teams to meet the health challenges ahead. Three Campaign Objectives support our ability to Create Capacity: 1) **maintaining, restoring** and **improving** health, 2) **ensuring accountable, reliable** and **effective health services**, and 3) providing a **consistent** superb **patient experience** across Army Medicine. These three objectives capture the mission and the means to provide the essential strategic framework for our enabling initiatives and programs.

LOE 1 – Capacity Conclusion. Creating capacity is about engaging every member of the Army Medicine team to understand that his and her vital contributions will drive our transformation to a System For Health. These objectives create capacity through engaged governance, stewardship of resources and effective, efficient processes that frame consistent standards to equip our commanders and medical teams for success. Building capacity is not about simply doing more, it is about doing things better with consistent unity of effort for dependable results. Every Soldier and Civilian in Army Medicine is an essential team member in this close fight to make health a powerful strategic weapons system to keep our Army and consequently our Nation strong.

Each of us needs to be able to explain where we fit: how do I **maintain, restore** and **improve** health? How do I create the ideal **consistent patient experience**? And how do I align resources to provide **reliable** and **effective** health care? Evidence based practices will shape our care for Soldiers and Families in a consistent manner where they live and work. Army Medicine can lead the Nation in health.

LOE 1 – Capacity Outcome. Strategic enabler that maintains, restores, and improves health.

Campaign Objective (CO) 1-1 Maintain, Restore and Improve Health

Goal: Army Medicine creates capacity with Soldier-and Patient-Centered care while improving health. We continue to build on the compassionate and quality health care provided at home and in austere combat environments to maintain and restore health. Army Medicine is committed to ground-breaking research, innovative training, education and initiatives to treat complex physical and psychological wounds of our Soldiers and Families. We strive to move further than traditional health care to improve the health of our force. Our initiatives include new means to impact our beneficiaries’ Lifespace. Our goal is a stronger, healthier ready Army and Army Family.

Key Metrics:

- Increase Survivability Rate
- Improve Post Traumatic Stress Disorder (PTSD), Traumatic Brain Injury (TBI), and Depression Treatment Outcomes
- Increase Percent of Soldiers who are Medical Readiness Classification (MRC) 1 & 2 (All Components)

Programs and Projects:

- 1-1.1 Globally Ready Medical Force
- 1-1.2 Behavioral Health System of Care
- 1-1.3 Complex Battle Injury
- 1-1.4 Traumatic Brain Injury
- 1-1.5 National Intrepid Center of Excellence
- 1-1.6 Medical Readiness

Program 1-1.1 Globally Ready Medical Force

Description: This program provides Medical Forces across the range of military operations through the contribution of five components to ensure a trained and ready Medical Force: Force Management, Manning to include the Professional Filler System (PROFIS), Training, Equipping and Mobilization.

Program 1-1.2 Behavioral Health System of Care (BHSOC)

Description: Behavioral Health System of Care provides consistent and ready access to behavioral health services across the health continuum (pre-clinical through post-hospitalization follow-up) and across the Soldier Life Cycle (initial entry through exit from service), delivered by the most appropriately trained and credentialed provider for the individual's presenting problems and diagnoses.



Program 1-1.3 Complex Battle Injury (CBI)

Description: Complex Battle Injury provides both training and education for our medical providers, as well as, research and implementation of Best Practices for our Wounded Warriors.

Program 1-1.4 Traumatic Brain Injury (TBI)

Description: The Traumatic Brain Injury (TBI) program provides comprehensive patient-care services across the continuum of care designed to prevent, identify, and mitigate the effects of TBI.

Program 1-1.5 National Intrepid Center of Excellence (NICoE)

Description: National Intrepid Center of Excellence program is designed to develop and deliver a course of action plan for the implementation of the six Army-operated NICoE satellite (NICOE-SAT) facilities that will ensure the delivery of effective and efficient care to Soldiers with complex, co-morbid medical conditions.

Program 1-1.6 Medical Readiness

Description: The Medical Readiness program is designed to improve medical readiness through distribution of educational material, active socialization of initiatives, and monthly reporting of metrics on all components.



Campaign Objective (CO) 1-2 Accountable, Reliable and Effective Health Service

Goal: This objective defines the strategic means and ways for Army Medicine to Create Capacity through good stewardship and alignment of our human, fiscal and facility resources. We utilize a resource and investment framework that is compliant with Operating Company principles, directly linked to plans and performance evaluated by relevant and reliable metrics. We value outcomes over activity as we generate cost effective capacity to impact the lives of more beneficiaries. Army Medicine will demonstrate its vast Nation-strengthening value by improving health and satisfaction while reducing unwarranted variation, waste and controlling costs, thereby shaping the future of global healthcare.

Key Metrics:

- Increase Percent Healthcare Effectiveness Data and Information Set (HEDIS) compliance
- Decrease Per Member Per Month (PMPM) cost
- Increase percent performance plan achieved

Programs and Projects:

- 1-2.1 Cost Management
- 1-2.2 Resource and Investment Framework
- 1-2.3 Information Management/Information Technology Mobility Plan
- 1-2.4 Service Lines (Reduce Clinical Variance)
- 1-2.5 Integrated Disability Evaluation System
- 1-2.6 Team Building and Training

Program 1-2.1 Cost Management

Description: The Cost Management program is designed to achieve a sustainable and competitive cost of operation by employing an enterprise cost management program.

Program 1-2.2 Resource and Investment Framework

Description: This program implements an effective resource and investment framework that aligns resources to strategy and performance plans.

Program 1-2.3 Information Management/Information Technology (IM/IT)

Description: The Information Management and Information Technology program is designed to develop enterprise-class solutions where technology supports improved health and health services delivery.

Program 1-2.4 Service Lines (Reduce Clinical Variance)

Description: The Service Line model identifies evidence based practice and tools to set standardized clinical practices throughout that domain of practice which will decrease variance, implement the operating company model, and emphasize standardization across the enterprise.

Program 1-2.5 Integrated Disability Evaluation System (IDES)

Description: The IDES process is Soldier- and Family-centered, which is designed to increase the readiness of the total Army by effectively managing Medically-Not-Ready (MNR) Soldiers through the disability process by standardizing processes, reducing variance and emphasizing transparency.



Program 1-2.6 Team Building and Training

Description: Organizational Development Teams will deliver specialized training and support services throughout the AMEDD which create a more responsive and reliable Army Medicine Workforce fully aligned to strategic goal achievement by developing highly self-aware individuals and engaged work Teams.

Campaign Objective (CO) 1-3 Consistent Patient Experience (CPE)

Goal: The Consistent Patient Care Experience creates capacity with improved health outcomes by creating the ideal patient experience. CPE focuses on patient safety, satisfaction and the seamless health support for Soldiers and Families across the life spectrum. These initiatives include the standardization of services across Army Medicine and a medical system for our beneficiaries to easily navigate and transition. Partnered with our patients and communities, we promise to make each care experience patient centered.

Key Metrics:

- Increase percent patient overall outpatient visit satisfaction
- Increase percent patient overall inpatient satisfaction
- Increase percent Primary Care Manager (PCM) continuity
- Decrease percent medication errors
- Increase effectiveness of seamless transition

Programs and Projects:

- 1-3.1 Patient Centered Medical Home (PCMH)
- 1-3.2 Pain Management
- 1-3.3 Partnership for Patients (PfP)
- 1-3.4 Patient Caring Touch System (PCTS)

Program 1-3.1 Patient Centered Medical Home (PCMH)

Description: PCMH program encompasses all primary care delivery sites in the direct care system and builds a premier Army medical System For Health through comprehensive transformation into a Patient-Centered, team-based accountable care organization.

Program 1-3.2 Pain Management

Description: This program leverages multiple modalities to relieve acute pain, minimize progression to chronic pain, maximize function, decrease disability and optimize treatment of those Soldiers and their Families with chronic pain in such a manner to minimize suffering and maximize quality of life through phased deployment of skilled teams and educational products across Army Medicine.



Program 1-3.3 Partnership for Patients (PfP)

Description: Partnership for Patients (PfP) brings together Leaders, physicians, nurses and patient advocates, along with community partners, in a shared effort to make hospital care safer, more reliable and less costly which will create an environment within the direct-care system that maximizes Health and minimizes unintended outcomes.

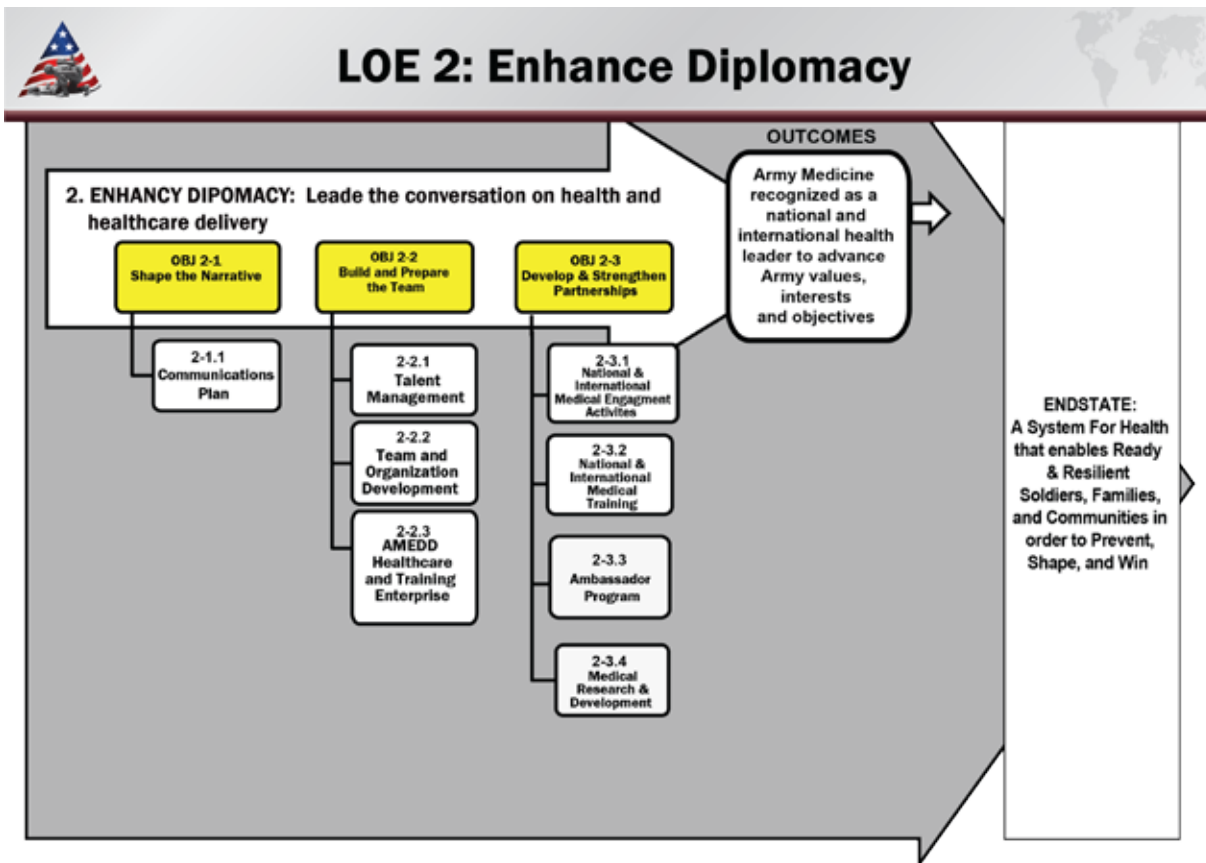
Program 1-3.4 Patient Caring Touch System (PCTS)

Description: Patient Caring Touch System (PCTS) is designed to reduce clinical quality variance by adopting a set of internal and external best practices to improve the quality of care for patients and their Families which will foster excellence, reduce clinical quality variance and maximize Health for our beneficiaries.

b. Strategic Imperative - Enhance Diplomacy

From Army Medicine Strategy - The Road Ahead (v2.B as of 29 August 2012)

Enhance Diplomacy – participating and shaping dialogue on healthcare delivery and individual health in Army, DoD, national and international communities in order to build federal, national and international enduring relationships that use medical diplomacy to advance Army values, interests and objectives.



Line of Effort (LOE) 2 – Enhance Diplomacy

Enhancing diplomacy, in particular medical diplomacy, enables Army Medicine to be recognized as a national and international health leader. Army Medicine expands diplomacy and communication efforts through demonstrable actions, provides resources and harnesses the power of the Internet and social networking to execute effective programs, projects and initiatives. Army Medicine enhances diplomacy and communicates the Army Medicine story to external audiences (the Public, Congressional and DoD), internal audiences (Army and Army Medicine), and international audiences (Nation States and collaborative partners). The following key concepts are associated with medical diplomacy:



Medical Diplomacy and Congressional Interaction. The Army's objectives with respect to Congressional interaction are to broaden advocacy and understanding, build trust and confidence, and to resource and authorize the Army. Congressional engagement activities encompass informal and formal written correspondence, telephonic and face to face interactions. The AMEDD goal is to educate, inform and establish an ongoing dialog with Congress. Typical engagement activities include subject matter expert briefings and office calls. Contact between Army commanders and Army officials and Members of Congress is encouraged to ensure Members of Congress are informed as part of Congressional oversight responsibilities.

Medical Diplomatic Partnerships and Engagements. Medical diplomatic engagements differ from medical diplomatic partnerships in that they are discreet events that are designed to meet a one-time purpose and intent. Typical engagement activities are visits, subject matter exchange visits, office calls and may even be conducted as Medical Readiness and Training Exercises (MEDRETE) and Cooperative Medical Engagements (CME). Conversely, partnerships are those relationships for which there is a longer term commitment with purpose and intent to the relationship. The primary example of a partnership in the current environment is building partner capacity. Principal past, present and proposed partnerships are prosthetics and rehabilitation care improvements with Pakistan and Georgia, pre-deployment combat support hospital training with the United Kingdom and negotiation for the placement of Foreign Liaison Officers (FLO) with German and Israeli Forces.

Harnessing the Power of the Internet and Technology in Medical Diplomacy.

People have more access to the Internet than clean water. There are more cell phones in the world than tooth brushes. More than seventy percent of the world's population has a cell phone, and major social media sites generate more than one billion instant messages every 24 hours, all while the world's most significant news events are delivered to our smart phones as they occur. By 2020, more than two-thirds of the world's population will have an Internet connection, meaning three billion new minds will connect to the global conversation. This sets the conditions for landmark advances in cloud computing, sensors, robotics, 3D printing, synthetic biology, digital medicine, artificial intelligence and more. Through the use of artificial intelligence, Army Medicine can better assist clinicians in developing countries arrive at correct diagnoses, and Army Medicine will always be there to help heal the patient.

(www.ted.com/talks/peter_diamandis_abundance_is_our_future.html)

LOE 2 – Diplomacy Outcome: Army Medicine recognized as a national and international health leader to advance Army values, interests and objectives.

Campaign Objective (CO) 2-1 Shape the Narrative

Goal: To shape the internal and external healthcare dialogue through a comprehensive communication plan addressing healthcare delivery and individual health in the Army, the Military Health System (MHS), DoD and national and international communities. Engaging in dialogue with key messages builds enduring federal, national and international relationships that advance Army values, interests and objectives. The communication plan supports the strategic framework for the transformation from a healthcare system to a System For Health.



Key Metrics:

- Percentage of Army Medicine personnel demonstrating knowledge of the strategic intent and key messages

Programs and Projects:

2-1.1 Communications Plan

Program 2-1.1 Communications Plan

Description: The Communications Plan communicates the concepts identified in the *Army Medicine Strategy – The Road Ahead (v2.B as of 29 Aug 2012)* and identifies the Who, What and Why for this “call to action.” It provides communication, dialogue and socialization plan for the operational and tactical frameworks for transforming Army Medicine from a healthcare system to a System For Health

Campaign Objective (CO) 2-2 Build and Prepare the Team

Goal: Every member of Army Medicine has a responsibility to engage internal and external stakeholders to advance medical diplomacy. The Public Affairs Office identifies core themes for all Army Medicine personnel to use when interacting with audiences. We will provide training on and links to these Army Medicine key messages. From the medic to The Surgeon General, we engage multiple audiences with a variety of messages. Critical tasks include: identifying the creation of timely and enduring Army Medicine messages, training all team members on these messages, and developing updated and audience-specific themes for use during engagements; leveraging our diversity to maximize engagement opportunity success; training our Army Medicine Ambassadors to conduct strategic engagements; and deploying organizational development teams across Army Medicine to deliver support services and enhance responsibility, collaboration and influence.

Key Metrics:

- Percentage of Army Medicine personnel that understand and communicate the vision and the three Strategic Imperatives of Army Medicine
- Percentage of AMEDD C&S courses with relevant “Army Medicine Story” content

Programs and Projects:

2-2.1 Talent Management

2-2.2 Team and Organizational Development

2-2.3 AMEDD Healthcare Education and Training Enterprise

Program 2-2.1 Talent Management

Description: Talent management provides an increasing focus in human resource management on the planned and strategic management of employees. Activities within talent management include: talent acquisition succession planning, assessment, development compensation and high potential management, which will ensure that Army Medicine attracts, selects, trains, develops, retains, promotes and assigns Soldiers and employees throughout all levels of the organization.

Program 2-2.2 Team and Organizational Development Directorate (TODD)

Description: Team and Organizational Development Directorate (TODD) program is designed to



improve confidence and trust, and increase awareness of Army Medicine based upon the following three imperatives:

- a. Improved Employee Engagement
- b. Improved Operational Performance
- c. Improved Patient/Beneficiary Satisfaction

This will create a more responsive and reliable Army Medicine workforce fully aligned to strategic goal achievement by developing highly self-aware individuals and engaged work teams.

Program 2-2.3 AMEDD Healthcare Education and Training Enterprise

Description: AMEDD Healthcare Education and Training Enterprise is a program that facilitates a force that is trained and educated on healthy activities/lifestyles, improves readiness.

Campaign Objective (CO) 2-3 Develop and Strengthen Partnerships

Goal: Develop and strengthen relationships in multiple venues that advance recognition of Army Medicine's leadership and role in enabling ready and resilient Soldiers, Families and Communities.

Key Metrics:

- Increase the number of recurring engagement activities
- Increase the number of Ambassadors with a social media presence

Programs and Projects:

- 2-3-1 National and International Medical Engagement Activities
- 2-3-2 National and International Medical Training
- 2-3-3 Ambassador Program
- 2-3-4 Medical Research and Development

Program 2-3.1 National and International Medical Engagement Activities

Description: International Medical Engagement Activities program supports The Surgeon General's medical engagement intent and the Operational Commander's Theater Campaign Plans. Activities include partnering with the joint, interagency and the international community. This program supports host nation capabilities by providing medical forces to conduct health engagement operations.

Program 2-3.2 National and International Medical Training

Description: National and International Medical Training program conducts medical engagement activities with partner nation military medical departments in order to co-develop mutually beneficial capabilities and capacities to address shared military medical interests and issues.

Program 2-3.3 Ambassador Program

Description: The Army Medicine Ambassador Program is a strategic engagement initiative and formal program to tell the Army Medicine, Army Health and Army Readiness story and is a key promotional initiative of The Surgeon General and the command as a whole that relate to health and healthcare.

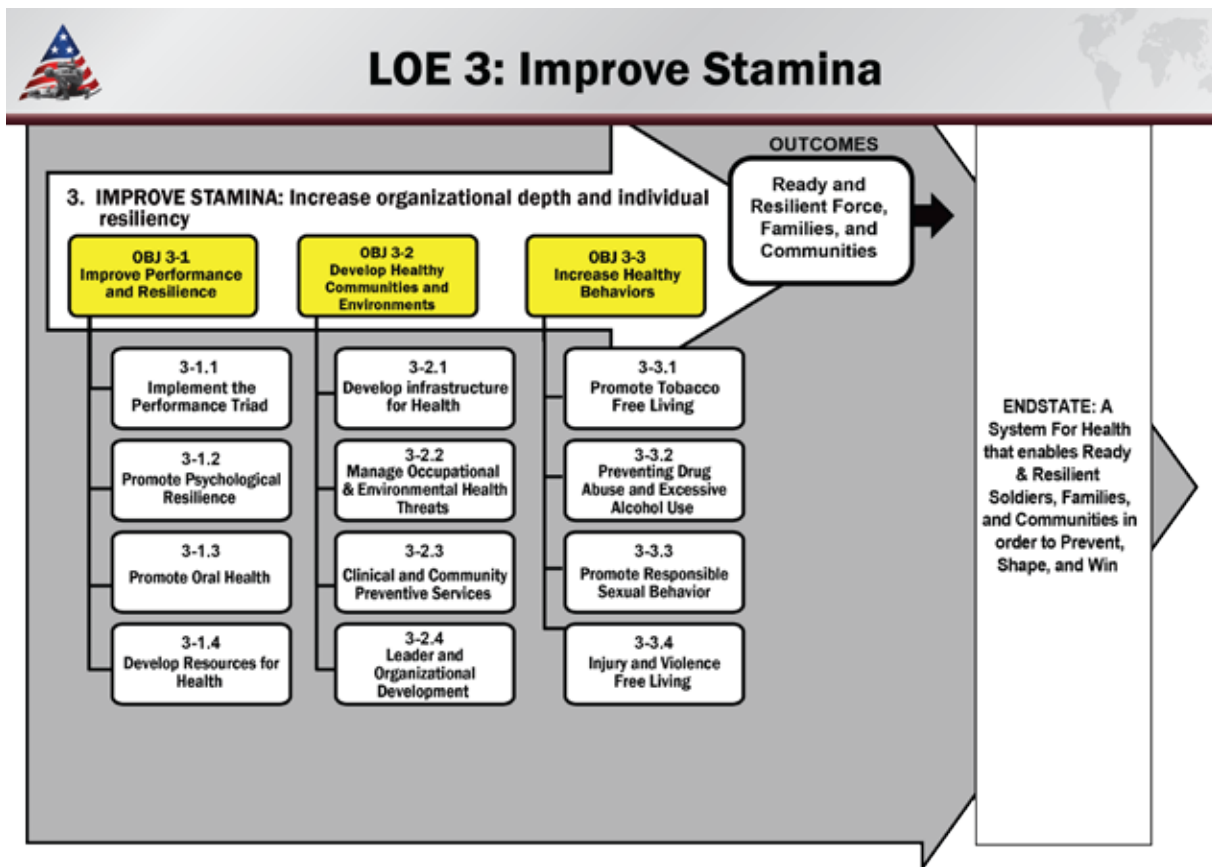
Program 2.3-4 Medical Research and Development Program

Description: The Medical Research and Development Program supports Research Development Testing & Evaluation (RDT&E) efforts within the Command, as well as provide a means for professional education within TDA Medical Treatment Facilities (MTFs).

c. Strategic Imperative - Improve Stamina

From Army Medicine Strategy – The Road Ahead (v2.B as of 29 August 2012):

Increase organizational depth, resiliency and endurance in order to withstand periods of intense change and unexpected challenges, and ensure that the Army Medicine System For Health is sustainable over the long-term.



Line of Effort (LOE) 3 – Improve Stamina

Stamina is the ability of individuals and organizations to expend effort over time. Increased stamina makes prolonged activity more sustainable and facilitates short bursts of activity when unforeseen challenges arise. Improving individual and organizational stamina is the main effort of the Army Medicine 2020 Campaign. This is an Army-wide, global mission. The goal of this LOE is to improve stamina across the Army by increasing physical and psychological resiliency, endurance and organizational depth.

Army Medicine must increase both individual and organizational stamina to withstand the transformation from a healthcare system to a System For Health, and then sustain the System for Health for years to come.



At the individual level, improved health and physical and mental resilience translate into improved stamina. The World Health Organization defines Health as the “complete physical, mental and social well being, and not merely the absence of disease or infirmity.” Health is an integral component of readiness and Army Medicine and Army Leaders must better prepare our Soldiers, Families and communities to mitigate the health risks facing them every day.

Organizational stamina focuses on long-term sustainability of the Army’s System For Health. Organizational stamina is built by improving and refining our infrastructure, training, leader development, management processes, knowledge sharing and ability to innovate. By doing this we will create organizational depth and an enduring operating model.

This line of effort has three main objectives:

- 1) Improve Performance and Resilience
- 2) Develop Healthy Communities and Environments
- 3) Increase Healthy Behavior

These objectives cover traditional clinical and community preventive services, to include an emphasis on the Performance Triad of Activity, Nutrition and Sleep. The objectives also include initiatives outside of traditional AMEDD missions, such as community planning for a “built environment” that supports and promotes healthy living. The LOE also includes resourcing functions and leader and organizational development initiatives that are critical to implementing and sustaining a System For Health.

LOE3 – Improve Outcome: Ready and Resilient Force, Families and Communities

Campaign Objective (CO) 3-1: Improve Performance and Resilience

Description: This objective improves physical and psychological performance and resilience by increasing awareness, setting conditions and instilling personal and leader responsibility through well-resourced programs that promote healthy behaviors, reduce preventable injury and disease, decrease dependency on treatment and empower people to lead healthier lives. Improved performance and resilience enhance stamina, mission accomplishment and readiness.

Key Metrics:

- Increase Percentage of beneficiaries who fall within ideal body weight
- Improve return to duty rates (organizational level)
- Increase percentage of Soldiers Medical Readiness Classification (MRC) 1 & 2
- Percentage improvement in Army Physical Fitness Test (APFT) scores

Programs and Projects:

- 3-1.1 Implement the Performance Triad (Activity/Nutrition/Sleep)
- 3-1.2 Promote Psychological Resilience



3-1.3 Promote Oral Health

3-1.4 Develop Resources for Health

Program 3-1.1: Implement the Performance Triad (Activity/Nutrition/Sleep)

Description: Army Medicine's operational approach to improve Soldier and Family health and stamina will focus on the Army Medicine Performance Triad of Activity, Nutrition and Sleep Management (ANS). The Performance Triad will develop MEDCOM strategy and action plans leveraging programs, initiatives and Subject Matter Experts within Army Medicine, Department of Defense and the civilian sector in order to improve stamina (fitness, resiliency, readiness and health) of Soldiers, Families and communities. This will result in healthy and resilient Soldiers, Families and communities with life skills and habits that promote health, life-fitness and readiness.

Program 3-1.2 Promote Psychological Resilience

Description: Psychological resilience is the ability to bounce back from psychological stressors and function effectively under stressful conditions. MEDCOM supports Army Readiness and Resiliency Campaign objectives by providing quality behavioral health (BH) care. This includes integrating and embedding behavioral health expertise and programs into operational units, the community and the Medical Home.

Program 3-1.3 Promote Oral Health

Description: Oral health will improve and sustain Dental/Medical readiness and oral health through clinical and community oral health promotion and disease prevention programs.

Program 3-1.4 Develop Resources for Health

Description: Improving stamina through a System For Health will require revolutionary changes in the way resources are forecasted, allocated, executed and managed and provides ongoing effective resource management for initiatives that support stamina while also focusing considerable thought and effort to research, develop, coordinate and implement novel resourcing models.

Campaign Objective (CO) 3-2: Develop Healthy Communities and Environments

Goal: Healthy and safe communities contribute to the health and wellbeing of Soldiers, Family members, employees and Retirees. The goals of this objective are to promote healthy communities and environments in deployed and garrison settings by partnering with installation and community leaders to develop a healthy built environment and establishing an infrastructure for health. Early identification/management of occupational and environmental exposures and the use of evidenced-based clinical and community services to prevent diseases and injuries are also critical for healthy communities. Leader and organizational development initiatives are key enablers that underlie all of the stamina objectives. These include programs and processes that provide governance, identify, and operationalize best practices, monitor outcomes, and implement policy, doctrine, technology, and education and research programs.

Key Metrics:

- Increase percentage of installations that have standardized Army Wellness Centers (AWC) and Community Health Promotion Councils (CHPC)
- Increase percentage of installations that have completed a Creating Active Communities and Healthy Environments (CACHE) Assessment and implemented an action plan



- Reduction in Federal Employee Compensation Act (FECA) claims and Occupational Safety and Health Administration (OSHA) violation
- Increase compliance with US Preventive Services Task Force (USPSTF) recommendations
- Decrease in non-approved programs; Increased standardization

Programs and Projects:

- 3-2.1 Develop Infrastructure for Health (Facilities and Organizations)
- 3-2.2 Manage Occupational & Environmental Health Threats
- 3-2.3 Clinical and Community Preventive Services
- 3-2.4 Leader and Organizational Development

Program 3-2.1 Develop Infrastructure for Health

Description: The Infrastructure for Health program is designed to develop, maintain and improve health facilities and is to proactively influence the development of installations and organizations that promote health.

Program 3-2.2 Manage Occupational & Environmental Health Threats

Description: This program manages occupational and environmental exposures, including industrial and arthropod borne disease, through consistent monitoring and effective prevention, mitigation and response activities with systems and processes to provide a comprehensive Common Operating Picture of public health threats, decrease morbidity and mortality from occupational and environmental hazards, and reduce costs and regulatory violations.

Program 3-2.3 Clinical and Community Preventive Services

Description: Preventive Services consist of screening tests, counseling, immunizations or medications used to prevent disease, detect health problems early or provide people with the information they need to make good decisions about their health.

Program 3-2.4 Leader and Organizational Development

Description: This program incorporates operating company principles and develops processes to identify, evaluate, select and operationalize best practices for programs that improve stamina which will improve organizational stamina by improving and refining training, leader development, management processes, knowledge sharing and the ability to innovate.

Campaign Objective (CO) 3-3: Increase Healthy Behavior

Goal: The goal of Increase Healthy Behavior is to improve individual, Family and organizational stamina by encouraging healthy lifestyles and healthy living. This includes, but is not limited to, educating individuals and promoting accountability for responsible behaviors. Prevention of drug abuse, excessive alcohol use and promotion of tobacco-free living also encourage healthy lifestyles. Engaging leaders and holding them accountable for setting conditions that promote healthy choices and reduce domestic, sexual and workplace violence, hazing, bullying, and suicide will be a key component of this objective. Reducing preventable injuries (e.g., sports injuries) which directly impact the readiness of the Force are also components to be emphasized.



Key Metrics:

- Decrease percentage of individuals using tobacco products
- Decrease percentage of individuals who endorse binge drinking in the past 30-days
- Decrease percentage of individuals who report excessive drinking
- Decrease Sexually Transmitted Disease (STD) rates
- Decrease disease and injury rates
- Decrease rates of domestic and sexual violence

Programs and Projects :

- 3-3.1 Promote Tobacco Free Living
- 3-3.2 Preventing Drug Abuse and Excessive Alcohol Use
- 3-3.3 Promote Responsible Sexual Behavior
- 3-3.4 Injury and Violence Free Living

Sub-Objective 3-3.1 Promote Tobacco Free Living

Description: This program will substantially decrease tobacco use by changing the Army culture on tobacco. This will reduce morbidity and mortality rates from tobacco-related diseases in Army beneficiaries and increase the proportion of medical treatment facility (MTF) campuses and other areas on Army installations that are tobacco free.

Sub-Objective 3-3.2 Prevent Drug Abuse and Excessive Alcohol Use

Description: This program is designed to educate and train beneficiaries in regards to practice of moderation when consuming alcohol and abstinence from illicit drug use with the primary goal of decreasing morbidity and mortality from alcohol and drug related incidents and diseases.

Sub-Objective 3-3.3 Promote Responsible Sexual Behavior

Description: This program will monitor sexually transmitted disease (STD) and sexually transmitted infection (STI) rates for Army beneficiaries and is designed to develop, implement and monitor initiatives that promote healthy sexual health practices.

Sub-Objective 3-3.4 Injury and Violence Free Living

Description: Injury and Violence Free Living program enhances transportation safety, prevent injuries in the workplace, prevent falls and prevent violence of all kinds is designed to enhance readiness by reducing preventable injuries and accidents at home, work and play; reducing domestic, sexual and workplace violence; and reducing hazing, bullying and suicide.



a. Organizational Chart



Other mission control support elements include the weekly Campaign Synchronization Working Group (CSWG) and the monthly (with continuous assessment) Campaign Assessment Cell (CAC). The CSWG will receive and track CAP-B results and decisions and will monitor the status of Army Medicine CPO(s), to include program(s) and projects(s). The CSWG will provide recommended changes to priorities/resource allocation, support and recommend priority of planning effort, and provide products in support of decision making processes. The CAC will oversee the overall campaign plan assessment, measure the progress with regard to outcomes, provide guidance and decisions, recommend changes on priorities, review operational priorities, and coordinate information and decision products, to include briefs or papers. Please refer to Annex G – Campaign Assessment and Performance Management for further details.

The Army and MEDCOM/OTSG system of record for AM 2020 CP assessment and performance is the internet-based Strategic Management System (SMS).



Annex A Line of Effort (LOE) 1 Create Capacity Programs & Projects

Program 1-1.1 Globally Ready Medical Force

1. Description: As part of the Joint Force and America's Army, in all that it offers, the Army Medical Team enables agility, versatility and depth to Prevent, Shape and Win. It is paramount that we remain grounded in history and integrate lessons learned and capabilities gained in recent operations into the Institutional and Operational Army. There are essentially five components that Army Medicine must contribute to ensure a trained and ready Medical Force. These components include: Force Management, Manning to include the Professional Filler System (PROFIS), Training, Equipping and Mobilization. With respect to Force Management, combat developers must ensure our organizational designs remain relevant, and force integrators must ensure the Army's End Strength includes the optimal size and mix of capabilities across our 11 medical functional areas. For Manning, we must ensure PROFIS Deployment System remains a responsive contribution from our Generating Force to our Operating Force. We will Train, Educate and Provide Leaders with experience. The 68W, Combat Medic, will remain a cornerstone of our Force Structure. In addition, we have embraced the need for flight paramedics for our aeromedical evacuation assets. We will continue to modernize our equipment to ensure success on the battlefield. We will continue to partner with our Reserve Component Medical Forces to mobilize Units and Individual Mobilization Augmentees (IMA) to fill the gaps created by our PROFIS deployment.

2. Objective: Provide Trained and Ready Medical Forces across the range of military operations.

3. Key Tasks(s):

- a. Design units that meet Combatant Commander needs
- b. Ensure a trained and ready Medical Force
- c. Ensure PROFIS capability meets requirements
- d. Equip units based on Army Priority List and synchronize with ARFORGEN cycle
- e. Maintain a viable mobilization plan that leverages United States Army Reserve (USAR) capabilities and backfills MTF and Installation Manning requirements

4. Measure(s) of Performance:

- a. Assess Medical Force structure via Total Army Analysis and routinely assess medical units for Force Design Updates (FDU) when required.
- b. Percentage of PROFIS personnel adequately notified in a timely manner in accordance with applicable policy.
- c. Fulfill Combatant Commander needs by participating in the ARFORGEN synchronization board and forecast PROFIS requirements
- d. Sustain 68W MOSQ Training and Certification program
- e. Percentage of 68WF3, Flight Paramedic, trained and certified
- f. Percentage of validated COCOM personnel augmentation requests that inform capability gaps (i.e. organizational design flaws).
- g. Percentage of validated COCOM equipment operational needs statements that inform capability gaps (i.e. organizational design flaws).

5. Measure(s) of Effectiveness:

- a. Improve Survivability Rate defined as the percentage of Soldiers who survive after receiving a massive blood transfusion.



- b. Improve Healthcare provider “Currency” Rate
- c. Percentage of PROFIS Backfill fulfilled by USAR in accordance with MEDCOM Mobilization Plan.

6. Assessment:

- a. Define (Metrics): Referenced in Measures of Performance and Effectiveness. In addition, we will conduct horizontal and vertical integrate of related programs across all three lines of effort.
- b. Information System: FMS Web, MODS, DTMS, eCOP, AST and netUSR.
- c. Frequency: Varies across major components of this program
- d. Feedback Mechanism: Campaign Assessment and Performance Dashboard (CAP-D), Review and Analysis, Combatant Commander after action reviews (AAR), Periodic Theater health service support (HSS) assessments, Action Officer Working Groups, Council of Colonels, and General Officer Steering Committees and Campaign Synchronization Working Group.
- e. Staff PropONENT: G-3/5/7 Health Care Operations

Program 1-1.2 Behavioral Health System of Care (BHSOC)

1. Description: The Behavioral Health Service Line will provide consistent and ready access to behavioral health services across the health continuum (pre-clinical through post-hospitalization follow-up) and across the Soldier Life Cycle (initial entry through exit from service), delivered by the most appropriately trained and credentialed providers.

Behavioral Health Service Line Program Evaluation critical elements include 1) using science as a basis for decision-making; 2) performing effectively as a service agency; 3) making efforts outcome-oriented; and 4) being accountable. The evaluation process will assess compliance with MEDCOM Policy, synchronization with approved clinical program models inherent in the service line plan, and effectiveness metrics. Population health outcomes will be monitored by the Public Health Command, and process effectiveness and outcomes will be assessed by MEDCOM Program Analysis and Evaluation.

Enablers for evaluation efforts include the Behavioral Health Data Portal (BHDP), which establishes a portal for standardizing and tracking Behavioral Health data for assessment. PA&E has developed the BH360 with BH related data in a site- based view for reports and expert analysis.

2. Objective: The desired end state is identifying projects for expansion, proliferation or discontinuation under the Behavioral Health Service Line, informing continued funding decisions, prioritizing BH expansion efforts, and recommending improvements and to achieve the most efficacious population and individual BH services for those we serve.

3. Key Tasks(s):

- a. Introduce authoritative standards of clinical practice to support comparison of performance from one installation to another, and to offer Soldiers and Families a uniformity of care experience at all locations. Instituting uniform metrics and standards to evaluate and monitor performance.
- b. Enabling visibility of behavioral health data to inform decisions and ensure accuracy
- c. Establishing an accountability and rewards structure to positively incentivize performance
- d. Develop MEDCOM strategic messages.



4. Measure(s) of Performance:

- a. Access to Care – percentage of appointments falling within access standards
- b. Provider Availability – Defense Medical Human Resources System Internet (DMHRSi) available time in clinic work center
- c. Utilization – Electronic Relative Value Unit (eRVU) production compared to MEDCOM standards
- d. Network productivity - leakage to network and potential for recapture
- e. Deployment Health Assessment – percentage of referrals completed within 90 days
- f. Financial Metrics - Obligation rates and returns from previous FY

5. Measure(s) of Effectiveness:

- a. Follow-up for discharged patients –appointment within 7 or 30 days
- b. Patient Satisfaction
- c. Behavioral Health Re-Admissions - inpatient readmission within 30 days
- d. Improved population-based BH treatment outcomes per the Behavioral Health Data Portal

6. Assessment:

- a. Information System: Strategic Management System, BH 360, and BH Data Portal.
- b. Frequency: As required
- c. Feedback Mechanism: BH Service Line
- d. Staff Propopent: G-3/5/7 Health Care Delivery

Program 1-1.3 Complex Battle Injury (CBI)

1. Description: This program will include both training and education for our medical providers, as well as research and implementation of Best Practices for our Wounded Warriors. We will train medical providers at all levels and to instill confidence in the medical system to treat and care for Warriors with CBI. We will lead advancements in protective technology and to implement Best Practices that provide improved holistic health-care across all echelons of care. We will conduct Surveillance and Trend Analysis in order to improve tracking of injured Warriors and to enable the identification of emerging injury patterns. Most importantly, we will provide Wounded Warriors the best opportunity to rehabilitate and reintegrate into the Force and/or Society.

2. Objective: Wounded Warriors and their Families are provided the best possible care, rehabilitation and long-term reintegration opportunities to return successfully to duty or civilian life.

3. Key Tasks(s):

- a. Conduct research and development within the medical sphere of influence to help prevent, protect or mitigate the effects of blast munitions.
- b. Conduct continuous and comprehensive data collection, surveillance and trend analysis of battlefield injuries.
- c. Provide the best care from the point of injury, through evacuation, and ending with long-term rehabilitation.
- d. Continually advance CBI care through improvements in training and research and development.
- e. Focus on the whole person approach of care by addressing the cognitive, emotional, spiritual and physical aspects of our Wounded Warriors and their Families.
- f. Develop an educational forum through which Warfighters and line leadership understand and embrace the medical work being conducted to protect them.



4. Measure(s) of Performance:

- a. Percentage Flight Medics trained to EMT-Paramedic:
 - 1) 30% in theater by SEP 13
 - 2) 60% in theater by SEP 14
 - 3) 100% of MOS by SEP 16
- b. Percentage medical evacuation flights (MEDEVACs) with intensive care unit (ICU) nurses to ROLE III Hospitals and ROLE III Hospitals to Landstuhl Regional Medical Center (LRMC) - 100% of flights by FY14
- c. Reduced infection rates among CBI patients by 1% per Quarter
- d. Percentage Urology Fellowship trained individuals at each training medical center (MEDCEN) – 100% by 2QFY13
- e. Decrease in time from evidence-based combat care enhancement to clinical practice guidelines (CPG) to a period of less than six months.

5. Measure(s) of Effectiveness:

- a. Reduction in died of wounds (DOW) rates
- b. Reduction in potentially preventable deaths at Point of Injury (POI)
- c. Reduction in deaths en route to definitive care (Role I to Role II/III to Role IV)
- d. Reduced morbidity and mortality of Wounded Warriors due to infections of trauma-induced wounds
- e. Improvement in quality of life satisfaction among CBI Warriors one year post injury

6. Assessment:

- a. Information System: Medical Occupational Database System (MODS) and Strategic Management System (SMS)
- b. Frequency: Quarterly
- c. Feedback Mechanism: Campaign Assessment and Performance Dashboard (CAP-D), Council of Colonels, and General Officer Steering Committees
- d. Staff Proponent: G-3/5/7 Health Care Delivery

Program 1-1.4 Traumatic Brain Injury (TBI)

1. Description: A comprehensive program to better prevent, diagnose, treat and track TBI. This program contains four essential elements: (1) a thorough baseline testing of all deploying Soldiers; (2) a comprehensive in-theater policy for assessing and treating Soldiers who may have been exposed to a potentially concussive event; (3) establishment of an expansive garrison clinical care program to meet the medical and rehabilitation needs of patients with all severities of TBI; and (4) an aggressive research program looking at ways to better diagnose and treat TBI.

2. Objective: Change the Army's cultural attitude regarding seeking care for traumatic brain injury and reduce the impacts of concussion / mTBI to improve Soldier health and well-being.

3. Key Tasks(s):

- a. Develop and deliver meaningful TBI education to facilitate timely TBI identification and minimize the short and long term effects of TBI in our Soldiers and beneficiaries. Ensure timely updates to educational products to reflect current clinical practices.
- b. Refine the science behind existing treatment protocols and maximize the appropriate utilization of our medical assets.



- c. Implement a TBI tracking system that leverages the advantages of automation and minimizes the bandwidth requirement.
- d. Develop, consolidate and monitor relevant Information Technology and Telehealth to improve access to care, database management, outcomes monitoring and value.
- f. Ensure system inspires team-based, data driven continual process improvement focusing on quality, evidence-based treatment and efficiency.
- g. Drive cultural change.

4. Measure(s) of Performance:

- a. Defense Training Management System (DTMS) completion rate for Army-wide one time education (per DA EXORD): > 60% by Jun 13, > 75% by Dec 13, > 95% by Sep 14
- b. Percentage of TBI designated deploying providers who attend the TBI for Deploying Providers two-day course: > 75% by Jun 13, > 85% by Dec 13, > 95% by Jun 14
- c. Validated Army TBI programs maintained at 58
- d. Staffing: < 20% vacancy in all identified authorized/required positions by Jun 13, < 10% by Sep 14
- e. Access to care timeliness, decrease waiting times by 3-5 days per year, sustain at < 2 weeks
- f. Percentage Soldiers followed-up for TBI that screen positive with symptoms for TBI: > 95% by Jun 13

5. Measure(s) of Effectiveness:

- a. Theater Return to Duty (RTD) Rate: Current: 95%; Sustain RTD > 95%
- b. Percentage of reported Soldiers involved in Mandatory events per Combined Information Data Network Exchange / Blast Exposure and Concussion Incident Report (CIDNE/BECIR) while deployed who are followed-up at Redeployment – Soldier Readiness Processing (R-SRP): Baseline, then increase 5% per year, Sustain >95%
- c. Patient Satisfaction: % patients at discharge satisfied with progress toward stated goals: Baseline, then increase 2-3% per year, Sustain >95%

6. Assessment:

- a. Information System: DTMS, BECIR, and CIDNE
- b. Frequency: Quarterly review of monthly Worldwide TBI data reported
- c. Feedback Mechanism: Campaign Assessment and Performance Dashboard (CAP-D), Council of Colonels, and General Officer Steering Committees
- d. Staff PropONENT: G-3/5/7 Health Care Delivery

Program 1-1.5 National Intrepid Center of Excellence (NICoE)

1. Description: Army NICoE-Satellite (NICoE-SAT) Facilities function as a portal for the most complex patients to access multidisciplinary assessment and interdisciplinary intense outpatient rehabilitation, with psychological health (PH) and mild traumatic brain injury (mTBI) conditions as their centers of gravity, where the care covers mTBI, PH, chronic pain, musculoskeletal, substance use and other related disorders, and the processes receives support from applicable AMEDD Service Lines and major programs, IMCOM, FORSCOM, TRADOC, VA and other federal and non-federal stakeholders.

2. Objective: Develop and deliver a course of action plan for the implementation of the six Army-operated NICoE-SAT facilities that will ensure the delivery of effective and efficient care to Soldiers with complex, co-morbid medical conditions.



3. Key Tasks(s):

- a. Develop and deliver a course of action plan for the implementation of the six Army-operated NICOE-SAT facilities.
- b. Ensure delivery of effective and efficient care to Soldiers with complex, co-morbid medical conditions
- c. Address psychological health (PH) conditions, and pain, musculoskeletal or substance use disorders.

4. Measure(s) of Performance:

- a. Initial Operating Capability one year prior to the Satellite(s) opening: > 90% of core clinical capabilities available in the direct or purchased care system; >70-80% of current onboard staff trained
- b. 800/900/1000 patients per year served by the Satellite staff in first/second/third year of operation; Sustain >1000 patients/year.
- c. Establish one new research protocol and one new education initiative each year; Increase one each year; Sustain at 2-3 new per year.
- d. Full Operating Capability at opening: ≥95% of staff on board; ≥95% of onboard staff trained to deliver core clinical capabilities.

5. Measure(s) of Effectiveness:

- a. Service Members who are RTD - 30% (1st year of operation)/40% (2nd year)/50% (3rd year)
- b. Soldiers/Families meet 60% (first year of operation)/70% (2nd year)/80% (3rd year) of other clinical treatment goals; Sustain >80%
- c. Soldier/Family, Leadership and Staff satisfaction - 70% (first year of operation)/80% (2nd year)/90% (3rd year) for each group; Sustain >90% each group

6. Assessment:

- a. Information System: Project Management Solution
- b. Frequency: Monthly
- c. Feedback Mechanism:
 - (1) Army mechanism: AMEDD GO Champion to DSG/TSG and VCSA
 - (2) Inter-service mechanism: NICOE Work Group/AMEDD GO Champion, thru JTF CAPMED, to SMMAC
- d. Staff Propont: G-3/5/7 Health Care Delivery

Program 1-1.6 Medical Readiness

1. Description: Army Medicine, MEDCOM in particular, executes a coordinated, synchronized and integrated comprehensive program to support Army Force Generation in each of its phases to increase the medical readiness of the Army. Improve medical readiness through distribution of educational material, active socialization of initiatives, and monthly reporting of metrics on all components.

2. Objective: MEDCOM, united with its Army partners, is committed to our cohesive effort to increase the medical readiness of the Army.

3. Key Tasks(s):

- a. MODS Support Contractor: Provide MRC and e-Profile data monthly
- b. MODS Program Manager: Summarize monthly MODS and e-Profile data, highlighting trends and providing potential explanations for changes in the data



- c. Health Policy and Standards: Provide monthly update on changes in policies and standards that may affect medical readiness
- d. Distribute educational materials and publish a Medical Readiness Leader's Guide
- e. Conduct training across a host of forums to include AMEDD Pre-Command Course, Brigade/Division Command Surgeon Course, S-1 Net, DCCS Community of Practice, and Company Commander/1SG Course

4. Measure(s) of Performance:

- a. Increase percent of Soldiers in Medical Readiness Classifications (MRC) 1 & 2 (All Components)
- b. Decrease percent of Soldiers in MRC4
- c. Ensure 100 percent utilization and conversion of Physical Profile DA Form 3349 to electronic profiling system (e-Profile)

5. Measure(s) of Effectiveness: Improvement in the above metrics due to commander and unit compliance at LAD

6. Assessment:

- a. Information System: MODS
- b. Frequency: Quarterly review of monthly Medical Readiness Report
- c. Feedback Mechanism: (BSC, Council of Colonels, GOSC) Monthly readiness report to MEDCOM leadership, Army professional forums, DCCS monthly meetings, monthly MEDPROS and e-Profile teleconferences, and quarterly readiness teleconference with RMC.
- d. Staff PropONENT: G-3/5/7 Health Care Operations

Program 1-2.1 Cost Management

1. Description: Promote a cost culture that supports an enterprise cost management effort that effectively plans, manages and controls costs to ensure sustainable health system per capita costs. Establish an enterprise cost management program that includes cost planning, cost accounting, cost analysis, cost controlling activities.

2. Objective: Achieve a sustainable and competitive cost of operation by employing an enterprise cost management program.

3. Key Tasks(s):

- a. Establish a cost management infrastructure capable of proactive cost controlling.
- b. Incorporate cost management as a key component of accountability to instill a cost conscious culture.

4. Measure(s) of Performance:

- a. Implement a cost management infrastructure that results in the attainment of industry benchmarks

5. Measure(s) of Effectiveness:

- a. Decrease Per Member Per Month (PMPM) cost to achieve a desired goal that incentivizes health
- b. Decrease Manage Cost Per Work Unit (varies by responsibility center) to achieve a desired goal that incentivizes health
- c. Decrease Administrative Cost Efficiency (ACE) Score to achieve a desired goal that incentivizes stewardship



6. Assessment:

- a. Information System: Army Cost Management Maturity Model (CM3)
- b. Frequency: Quarterly review of monthly CM3 Report
- c. Feedback Mechanism: Campaign Assessment and Performance Dashboard (CAP-D), Council of Colonels, and General Officer Steering Committees
- d. Staff Proponent: G-8/9 Performance Assessment and Evaluation

Program 1-2.2 Resource and Investment Framework

1. Description: Emplace a disciplined and transparent resource and investment framework that aligns resources, to include resource incentives, to strategy and performance planning as we optimize value. Plan, predict, secure, allocate, account, and effectively execute resources to achieve overall objectives of Army Medicine 2020.

2. Objective: Implement an effective resource and investment framework that aligns resources to strategy and performance plans.

3. Key Tasks(s):

- a. Translate strategy to action by aligning resources by major objective
- b. Ensure information system allows commands to benchmark progress using leading indicators

4. Measure(s) of Performance:

- a. Reduction in wasteful/unnecessary care expenditures
- b. Percentage of funding in direct support of key strategic initiatives
- c. Obtain resources necessary to execute approved plans
- d. Increasing investment in outcome over investments in activity

5. Measure(s) of Effectiveness:

- a. Reduction of Resource Use Burden Score for beneficiaries in the highest Illness Burden Category (Improve Health)
- b. Reduction in overall morbidity
- c. Receive unqualified audit opinion (transparency)

6. Assessment:

- a. Information System: Army Cost Management Maturity Model (CM3)
- b. Frequency: Quarterly review of monthly CM3 Report
- c. Feedback Mechanism: Campaign Assessment and Performance Dashboard (CAP-D), Council of Colonels, and General Officer Steering Committees
- d. Staff Proponent: G-8/9 Resource Management

Program 1-2.3 Information Management/Information Technology (IM/IT)

1. Description: Enhance information management and technology. Enablers include robust clinical informatics, enterprise architecture, capability management, strategic program management and enterprise-class infrastructure. Near-term IT solutions include deployment of enterprise email, mobility solutions, the enterprise collaboration initiative, deployment of consolidated Army Medicine business intelligence tools, and the G6 Strategic Program Office. Intermediate solutions include enterprise wide capability management in clinical and operational communications portfolios and unified infrastructure. Long term solutions include support for transition to the integrated Electronic Health Record.



2. Objective: Develop enterprise-class solutions where technology supports improved health and health services delivery.

3. Key Tasks(s):

- a. Support clinical IM/IT requirements with solutions integrated with DOTMLPF that supports providers and patients as they move to Health.
- b. Implement IM/IT capability management across Army Medicine that strengthens our partnership with operational medicine.
- c. Implement effective IM/IT portfolio management, financial accountability and governance that leverage technology.
- e. Implement effective Program Management that includes a process of acquiring and sustaining fully integrated and coordinated solutions that connect clinical and business communities as well as all Army Components.
- f. Address training capability gaps in the use of information systems across Army Medicine.
- g. Facilitate effective decision making.
- h. Build and implement IM/IT Workforce Development Plan.
- i. Align IT infrastructure to support all demands

4. Measure(s) of Performance:

- a. Percentage reduction of redundant or ineffective systems, applications or devices in the MEDCOM inventory
- b. Percentage of analysis and recommendations completed for iEHR transition plan
- c. Percentage of analysis completed of capabilities gap and prioritizations.

5. Measure(s) of Effectiveness:

- a. Success rate of IT products that meet users' requirements
- b. Dollars saved from IT standardization by reducing the practice of purchasing, sustaining, and training of multiple redundant systems
- c. Improved relationship and trust between the user community and concept/material developers.

6. Assessment:

- a. Information System: Enterprise of Clinical, Administrative, and Business systems
- b. Frequency: Range of real-time measures to monthly and quarterly reports
- c. Feedback Mechanism: G6/CIO has developed and will sustain a comprehensive action plan to ensure alignment of IM/IT resources to reduce variance and move to Health.
- d. Staff PropONENT: G-1/4/6 Information Management

Program 1-2.4 Service Lines (Reduce Clinical Variance)

1. Description: Service Lines are core teams focused on major AMEDD health domains with full visibility of assets, policies, services and resources. The teams will incorporate key stakeholders to assess domain performance, set policy, and build a collaborative enterprise community of practice. This includes the spectrum of health from promotion, maintenance, restoration and improvement. The Service Line model identifies evidence based practice and tools to set standardized clinical practices throughout that domain of practice. Service Line model establishes system-wide services and policies that promote collaboration and reduce redundancy.



2. Objective: Decrease Variance, implement the operating company model and emphasize standardization across the enterprise.

3. Key Task(s):

- a. Execute a phased implementation of seven Service Lines including: Behavioral Health, R2D, Primary Care, Telehealth, Women's Health, Operative, and Patient Care
- b. Ensure each Service Line includes the following capabilities:
 - 1) PICTURE: create common operating picture of services, scope, staffing, and equipping at each MTF
 - 2) POLICY: identify pertinent guidelines and practice recommendations, standards, compliance mechanisms. Develop a uniformed approach to maintain an integrative and interdisciplinary approach to patient care Office of Primary Responsibility (OPR): G6- Capability Management
 - 3) PERFORMANCE: identify metrics/MOE, MOPs in this domain of practice. Develop data base and dashboard for enterprise metrics. Establish systems for ongoing assessment and evaluation of policies and procedures Office of Primary Responsibility (OPR): G6- Resource / Investment
 - 4) PREPARATION: identify training necessary for the key services in this domain. Establish educational programs for patients, providers, and leaders that support best care practices
 - 5) PEOPLE: build a community of practice with MEDCOM, RMC and MTF personnel in this domain, tie to appropriate consultants, CSBPOs, Corps Chiefs and Deputies
 - 6) PROSPECTIVE: identify future trends to be considered in refreshing strategy

4. Measure(s) of Performance:

- a. Define Service Line Standards via Policies, SOPs, OPORDs
- b. Completion of Common Operating Picture dashboard for each Service Line
- c. Development of comprehensive service and staffing COP
- d. Telehealth capabilities offered at all MTFs
- e. All policies, SOPs, OPORDs published with measures of performance and effectiveness clearly defined to so as to facilitate sustaining and verifying compliance

5. Measure(s) of Effectiveness

- a. Improve Staff Engagement index on MEDCOM Speaks!
- b. RMC Commander satisfaction with MEDCOM Service Line support

6. Assessment:

- a. Information System: Strategic Management System, BH360, and APLSS
- b. Frequency: Quarterly
- c. Feedback Mechanism: RMC Review and Analysis, Council of Colonels, and General Officer Steering Committees.
- d. Staff Propopent: G-3/5/7 Health Care Delivery and Patient Care Integration

Program 1-2.5 Integrated Disability Evaluation System (IDES)

1. Description: The IDES process is Soldier- and Family-centered. It documents the presence of medical and/or psychological conditions that impact military occupational function, future civilian occupational capability and/or social interactions. This is a collaborative, non-adversarial process in which qualified medical providers perform the Compensation and Pension (C&P) Exam to VA standards for disability rating determination.



2. Objective: Increase the readiness of the total Army by effectively managing Medically-Not-Ready (MNR) Soldiers through the disability process by standardizing processes, reducing variance and emphasizing transparency.

3. Key Tasks(s):

- a. Resource: Staffing and facility requirements must be adaptable in order to meet current and projected throughput.
- b. Educate and train: Leaders, Soldiers and stakeholders must be thoroughly educated on the process and be expertly trained to carry out their respective roles and responsibilities.
- c. Partner: Continuous information sharing with key stakeholders (leaders, Soldiers, IDES personnel, PDA, VA partners) in order to manage expectations and achieve synchronization and transparency.
- d. Monitor: Develop and use standardized metrics to assist in continuous process refinement and identification of efficiencies and challenges.
- e. Enforce standards: Leaders at all levels adhere to and enforce standards and timelines; seek ways to minimize variation and increase predictability.

4. Measure(s) of Performance:

- a. IDES cases in MEB Stage should not exceed 35 days
- b. NARSUM(s) are dictated within 5 days
- c. IDES enterprise personnel ratios are achieved per required throughput
- d. MEB Providers achieve 20 NARSUMs per month/FTE

5. Measure(s) of Effectiveness - Calendar Year (CY) 13 year-end targets:

- a. MEB throughput of 3,000 cases per month
- b. Achieve the 295 day IDES standard for greater than 80% of cases
- c. Maintain an output/input ratio greater than 1 for the entire CY 2013
- d. Initiate greater than 50% of RC backlog cases

6. Assessment:

- a. Information System: Veterans Tracking Applications (VTA), Electronic Medical Evaluation Boards (eMEB), Electronic Physical Evaluation Boards (ePEB), Strategic Management System (SMS), and Defense Medical Human Resource System internet (DHMRSi)
- b. Frequency: Quarterly review of monthly IDES Reports
- c. Feedback Mechanism: Council of Colonels that report to numerous forums: Vice Chief of Staff Army (VCSA), Benefit Executive Council (BEC), Health Executive Council (HEC), and Joint Executive Council (JEC)
- d. Staff Propopent: G-3/5/7 Health Care Delivery

Program 1-2.6 Team Building and Training

1. Description: Organizational Development Teams will deliver specialized training and support services throughout the AMEDD. These services are designed to build highly functional and cohesive teams that respect and leverage diversity to optimize healthcare delivery and promote health. Services include, but are not limited to, Arbinger training, Begin with the BASICS course and Temperament Development Workshops.

2. Objective: Create a more responsive and reliable Army Medicine Workforce fully aligned to strategic



goal achievement by developing highly self-aware individuals and engaged work Teams.

3. Key Tasks(s):

- a. Develops liaison relationships with OTSG/MEDOCM One-Staff to rapidly identify AMEDD teams in need of facilitation services, as well as collaborate with ONESTAFF to develop internal teams.
- b. Specialize in aligning strategic messaging of System For Health across all training venues.
- c. Develop and implement IMPACT3, a six month program designed for senior leaders to enhance responsibility, collaboration and influence at the strategic level.
- d. Deliver specialized training designed to build highly functional and cohesive AMEDD teams.
- e. Conduct site assessment throughout the AMEDD to provide service excellence and assistance in the tenets of facilities improvement, standardization of care experience and customer relations improvements.

4. Measure(s) of Performance:

- a. TODD Trust Survey: Improved leader engagement as measured by iterant TODD trust survey scores (pre assessment score, post intervention 30 day score, 6 month and 12 month).
- b Improved operational performance metrics: decreased EEO, staff turnover, increased targeted recruitment capability MEDCOM Speaks.

5. Measure(s) of Effectiveness:

- a. Improved staff engagement and trust as measured by survey.
- b. Improvements in all monitored survey data for beneficiary satisfaction including; including MEDCOM Speaks, Army Provider Level Satisfactions Scores.

6. Assessment:

- a. Information System: Army Medicine Portal
- b. Frequency: Quarterly
- c. Feedback Mechanism: Monitor feedback from organizational leadership trained and adapts training accordingly.
- d. Staff Propopent: Team and Organization Development Directorate

Program 1-3.1 Patient Centered Medical Home (PCMH)

1. Description: The Army PCMH model encompasses all primary care delivery sites in the direct care system, including Community Based Medical Homes (CBMH) and Soldier Centered Medical Homes (SCMH). The CBMH was developed to address the complexities of operating in off-post. The SCMh was developed to address the complexities inherent in the integration of organic unit medical staff with installation medical treatment facility (MTF) staff. Together, both CBMHs and SCMhS are, by definition, Army Patient Centered Medical Homes. Each fully embody: PCMH common operating principles and standards; core performance metrics built on the patient experience of care, Soldier readiness, quality, safety, and operating efficiency.

2. Objective: Build a premier Army medical System For Health through comprehensive transformation into a patient-centered, team-based accountable care organization that improves Readiness of the Force and Health of our beneficiaries.



3. Key Tasks(s):

- a. Lead standards-based implementation of PCMH (includes Community Based and Soldier Centered Medical Homes). OPR- PCMH TF (Primary Action Officer- COL Mark Reeves); OCR- G-staff, RMC Transformation Teams.
- b. Stand-up Soldier Centered Medical Home (SCMH) across the Army with seamlessly integrated leadership and clinical teams from line and medical units. OPR- PCMH TF (Primary Action Officer- COL Mark Reeves); OCR- ACOM and ASCC Surgeons, G-staff, RMC Transformation Teams.
- c. Establish Primary Care Service Line. OPR- PCMH TF (Primary Action Officer- COL Mark Reeves); OCR- G3/5/7, G1 and G8
- d. Drive patient centered culture change. OPR- PCMH TF (Primary Action Officer- COL Mark Reeves); OCR- G-staff, RMC Transformation Teams.
- e. Align value based incentives with improving health outcomes and staff satisfaction. OPR- PCMH TF (Primary Action Officer- COL Mark Reeves); OCR- G357, G1, G2, G8
- f. Develop, consolidate and deploy relevant Information Technology and accessible, actionable data systems. OPR- PCMH TF (Primary Action Officer- COL Mark Reeves); OCR- G6, DSI, G3/5/7 (telehealth SL), G8, MHS Tri-Service PCMH Advisory Board.
- g. Ensure system inspires team-based, data driven continual process improvement focusing on safety, quality and efficiency. OPR- PCMH TF (Primary Action Officer- COL Mark Reeves); OCR- DCG Ops (Quality Management Office), G3/5/7 and G8.

4. Measure(s) of Performance:

- a. Readiness Index – Percentage of PCMH practices >7.5 in non-SCMHs, >12.8 in SCMHs
- b. Validated Army PCMH practices - >65 by Sep 13, >115 by Sep 14, >144 by Sep 15
- c. Percentage beneficiaries enrolled in TMA sanctioned PCMH practices- 45% FY13, 75% by FY14, 90% by FY15, 100% by FY16 (all benchmarks are beginning of FYs)
- d. Primary Care Service Line positions filled, managing primary care budget, distributing personnel, defining, communicating, accounting for primary care standards, improving current policy- FOC NLT end Q2 FY13 (>85% manned, well established in routine MEDCOM governance)
- e. Patient, staff, and leader satisfaction increasing by 2-3% per year; sustained >94%
- f. Percentage of current concepts (continuity, patient satisfaction, ER utilization, HEDIS composite, Readiness – MRC4, care coordination, virtual care conducted/deferred face-face visits, team based documentation, etc), incorporated into Performance Based Adjustment Model and coding guidance
- g. Percentage of practices, departments, MTFs, BDEs/DIVs, RMCs, and MEDCOM in which PCMH business and clinical dashboards are utilized to make informed decisions, improve processes, empower and hold leaders accountable
- h. Percentage practices with Ongoing and Focused Professional Practice Evaluation incorporating objective, team based, enrollee specific data documented in clinical PCMH data base
- i. Percentage practices in competition for Excalibur Award (or equivalent) for improvements in patient safety, quality or efficiency
- j. Percentage staff reporting feeling fully valued in practice level process improvement in anonymous staff satisfaction survey – baseline, then increase 2-3% per year, sustain >97%

5. Measure(s) of Effectiveness:

- a. MRC4 (Core): Current: 11%; Change: decrease 3% per quarter; Sustain: <3%
- b. MRC3B: Current: 7%; Change: <5% within 18 months (likely increase in first 6-12 months as service members (SM) move from MRC4 to MRC3); Sustain: <5%



- c. IDES - MEB phase: Current: 181 days; Change: <120 days in first year; Sustain: <100 days in 2nd year
- d. ER utilization (Core): Current: 50/100/yr; Change: decrease by 10/100 per year; Sustain: <30/100
- e. Network Leakage: Current: ~\$175 million to purchased care sector; Change: decrease by 30% per year from baseline established end of FY13; Sustain: <20%
- f. BH and PT no-shows: Current: 15% and 11%; Change: decreased by 50% in first 12 months; Sustain: <5%
- g. Per member per month costs (Core): Current: 9.7% average annual increase; Change: <7% per member in first 12 mos, <5% in second 12 mos; Sustain: <5% annual increase
- h. BH admissions (* data from FCCO eBH team experience- FY10à11): Current: 50/1000/yr; Change: decreased by 25% after 12 mos; Sustain: <30/1000/yr
- i. "Polypharmacy" (>3 BH meds + opioids): Current: 5.8% in SMs; Change: decreased by 20% in first 12 mos; Sustain: <1%
- j. Obesity Rate: Current: 29% of enrolled beneficiaries (obese = BMI >30; 61% SMs overweight – BMI >25); Change: decrease by 2% per year; Sustain: <5%
- k. HEDIS Composite (Core): Current: 20% MTFs with average performance >90% in 8 metrics; Change: increase % MTFs exceeding average of 90% by 5% per year; Sustain: >75% of MTFs exceed 90th percentile
- l. Continuity with PCM and PCM Home (BDE) (Core): Current: PCM- 55.2% / PCM home (BDE) 85.7% (BDE unknown); Change: increase 3% per year (enroll to BDE PCMs then achieve 90%); Sustain: PCM- >70% in non-SCMH, >60% in SCMH/ PCM home/BDE- >90%
- m. Satisfaction (Core) (patient/staff/leader): Current: 91%/ 60%/ n/a; Change: increase patient-2-3% per year (5% in SCMHs in 6 mos); Sustain: >94%
- n. In development: Performance Triad metrics, Tobacco Use, Injury Prevention, Time to RTD (MRC3As and 3Bs)

6. Assessment:

- a. Information System: Command Management System (CMS) and Strategic Management System (SMS)
- b. Frequency: Monthly-PCMH practice to MTF/BDE to RMC and PCMH TF and involved G-staff; Monthly MTF to RMC; Quarterly- RMC CGs to TSG or as specified in Soldier Readiness Campaign
- c. Feedback Mechanism: C2/Mission Command, Command Update Briefs/R&A, BSC, Soldier Readiness Councils
- d. Staff Propont: G-3/5/7 Health Care Delivery

Program 1-3.2. Pain Management

1. Description: We will execute a sustained comprehensive pain management campaign focused on prompt and appropriate treatment. The campaign seeks to relieve acute pain, minimize progression to chronic pain, maximize function, decrease disability and optimize treatment of those Soldiers and their Families with chronic pain in such a manner to minimize suffering and maximize quality of life. Leaders will execute an enterprise-wide approach to engage and integrate all assets available.

2. Objective: Provide synchronized, integrated, state-of-the-art and continuously improved system of care for Soldiers, beneficiaries, and their Families with acute and chronic pain. Army medical treatment facilities (MTFs) will minimize suffering, mitigate related adverse events, and optimize functional outcomes.

3. Key Tasks(s):

- a. Develop a uniformed approach to maintain an integrative and interdisciplinary approach to managing pain



- b. Identify program capabilities, resources needed and effective multimodal services
- c. Improve rehabilitation, reintegration and recovery through improved pain management
- d. Establish pain management as a priority, with an urgency that leads to a change in the culture and practice of pain management for patients, providers and leaders
- e. Establish educational programs for patients, providers and leaders that support best pain care practices
- f. Develop Army Medicine message in collaboration with DoD and Department of Veteran Affairs (VA)
- g. Provide requirements to the Planning, Programming, Budgeting and Execution System (PPBES) to sustain operations
- h. Establish systems for ongoing assessment and evaluation of pain management support programs
- i. Promote understanding and support by communicating approved Pain Management initiatives/programs to key audiences
- j. Support ongoing research activities, both intra- and extramural, that sustain the DoD pain management mission

4. Measure(s) of Performance:

- a. Designated pain management positions filled at OTSG, RMC HQ's and designated MTFs; 75% NLT FY14 ; 95% NLT FY15
- b. MEDCOM Interdisciplinary Pain Management Centers established at designated sites providing standardized package of services/modalities
- c. MEDCOM Pain Management Augmentation Teams established at designated sites
- d. TRI-Service/VHA process initiated to develop/deploy Pain Assessment Screening Tool and Outcomes Registry (PASTOR)
- e. Joint Regional Anesthesia and Analgesia Tracking System (JRAATS) approved as IT solution for pain management communication throughout the continuum of pain management during patient evacuation
- f. Pain Assessment Tool (DVPRS) validated for use across MEDCOM/DoD
- g. Percentage of recommended modules for DoD/VHA pain management curriculum available for distribution/integration; > 50% by end of FY 13, 80% by FY 14, 100% by FY 15
- h. MEDCOM MTFs integrated into Army Pain (Extension for Community Healthcare Outcomes) ECHO as either functioning hub or spoke along designated roll-out plan

5. Measure(s) of Effectiveness:

- a. Percentage of MTF Pain Clinics validated at designated tier capability for pain management: FY 13 50%; FY14 75%; FY 15 95%; FY 16 100%
- b. Percentage of Soldiers on Chronic Opioid Therapy: Baseline, then decrease 5% per year for three years; re-establish MOE objective following reassessment
- c. Pain Management Network Leakage at sites with functioning IPMCs: Change: decrease by 10% per year from baseline for year one; decrease 10% at year two; sustain
- d. Percentage improvement in Army Provider Level Satisfaction Survey (APLSS) Pain Satisfaction Questions; Increase 2-5% per year until above 95%
- e. Percentage staff satisfaction/self-efficacy in managing pain patients and making appropriate referrals/clinical decisions; increase in year one of Army Pain ECHO to greater than 80% for participants, year two of Army Pain ECHO greater than 95% for participants
- f. AD Opioid prescriptions (per 1000); baseline 46,000; decrease 5% per year for three years; re-establish MOE objective following reassessment
- g. Emergency Room (ER) utilization/1000 SM (pain medication related visit; unscheduled refill, medication change/increase): Baseline, then decrease 5% per year



- h. MEDCOM has heightened situational awareness of current trends in opioid use and abuse and has implemented strategy for pain management that includes targeted non-medication complementary modalities

6. Assessment:

- a. Information System: Strategic Management Systems and Integrated Electronic Health Record (iEHR)
- b. Frequency: Quarterly
- c. Feedback Mechanism: RMC Review and Analysis, Council of Colonels, and General Officer Steering Committees.
- d. Staff PropONENT: G-3/5/7 Health Care Delivery

Program 1-3.3. Partnership for Patients (PfP)

1. Description: Partnership for Patients (PfP) brings together Leaders, physicians, nurses and patient advocates, along with community partners, in a shared effort to make hospital care safer, more reliable and less costly. We will implement standardized Evidence Based Practices (EBP) for nine harm conditions and preventable readmissions throughout the organization for every patient, every time. The two focus areas are keeping patients from getting injured in hospitals or sicker and helping patients heal without complications.

2. Objective: Foster an environment within the direct-care system that maximizes Health and minimizes the change for unintended outcomes.

3. Key Tasks(s):

- a. Keep patients from getting injured or sicker.
- b. Help patients heal without complication.

4. Measure(s) of Performance: Partnership for Patients initiative identified 10 key indicators to be measured; nine preventable hospital-acquired conditions:

- a. Surgical site infections
- b. Venous thromboembolism
- c. Ventilator-associated pneumonia
- d. Obstetrical adverse events
- e. Central line-associated bloodstream infections
- f. Catheter-associated urinary tract infections
- g. Adverse drug events
- h. Falls
- i. Pressure ulcers
- j. Readmissions

5. Measure(s) of Effectiveness: Three types of measures, compliance, process and outcome, will be gathered on the on the ten harm categories as defined in the Department of Defense Implementation Plan for Military Health System's Participation in the PfP. In addition, each harm category has an implementation guide with the specified process and outcome measures.

6. Assessment:

- a. Information System: Strategic Management System, iEHR, and Interactive Customer Satisfaction System



- b. Frequency: Quarterly
- c. Feedback Mechanism: RMC Review and Analysis, Council of Colonels, and General Officer Steering Committees.
- d. Staff Proponent: Clinical Performance Assurance Directorate, Quality Management

Program 1-3.4. Patient Caring Touch System (PCTS)

1. Description: The Patient Caring Touch System (PCTS) is our framework for nursing. It was designed to reduce clinical quality variance by adopting a set of internally and externally best practices in order to improve the quality of care provided to patients and their Families. PCTS is a key enabler of Army Medicine's Culture of Trust. Recently implemented, we will continue to refine this program across the enterprise using structured, standards based methodology.

2. Objective: Foster excellence, reduce clinical quality variance, and maximize Health for our beneficiaries.

3. Key Tasks(s):

- a. Reduce clinical quality variance
- b. Adopt a set of internal and external best practices
- c. Improve the quality of care provided to patients

4. Measure(s) of Performance: Medical Treatment Facilities adhere to published PCTS standards.

5. Measure(s) of Effectiveness:

- a. Increase staff satisfaction (Nurse, LPN, 68W, etc)
- b. 100% pain assessment (outpatient), and pain reassessment (inpatient)
- c. Decrease falls rate and falls rate with injury
- d. Decrease medication error rate, and medication error rate with harm
- e. Evaluate best practices and implement clinical practice guidelines to reduce variance and improve care across the AMEDD

6. Assessment:

- a. Information System: Strategic Management System, iEHR, and Interactive Customer Satisfaction System
- b. Frequency: Quarterly
- c. Feedback Mechanism: RMC Review and Analysis, Army Nurse Practice Council, Council of Colonels, and General Officer Steering Committees.
- d. Proponent: Deputy Corps Chief for Army Nurse Corps



Annex B Line of Effort (LOE) 2 Enhance Diplomacy Programs & Projects

Program 2-1.1 Communications Plan (See Annex D)

1. Description: The Communications Plan is the execution of communicating the concepts identified in the Army Medicine Strategy – The Road Ahead (v2.B as of 29 Aug 2012). This plan identifies the Who, What and Why for this “call to action.” It takes action to communicate the vision, strategic imperatives and way ahead for Army Medicine. It provides communication, dialogue and socialization plan for the operational and tactical frameworks for transforming Army Medicine from a healthcare system to a System For Health and will assist in the messaging of Army Medicine as a global leader in healthcare and in health.

2. Objective: Ensure key stakeholders, Senior Army Leaders, Soldiers, Family members and other beneficiaries understand and are confident that Army Medicine is committed to setting the example for the Nation in quality healthcare for all those entrusted to its care.

3. Key Tasks:

- a. Analyze and determine the target audience
- b. Develop a social media strategy specifically for Army Medicine messaging
- c. Design and develop a blended communication strategy for strategic intent and key messages
- d. Develop a dynamic Army Medicine 2020 Campaign Media Plan
- e. Review the internal and external media products for consistency with stakeholders (MHS, DoD, VA, etc)

4. Measure(s) of Performance:

- a. Percentage of internal audience in receipt of the communication plan
- b. Percentage of the external audience in receipt of the communication plan
- c. Frequency of personnel accessing communication plan from SharePoint portal
- d. Frequency of request for communication plan from Army Medicine Directorate of Communication (DCOMM)

5. Measure(s) of Effectiveness:

- a. Universal use of communication plan strategy across Army Medicine Enterprise
- b. Synchrony of strategic messaging across Army Medicine
- c. Utilization of the communication plan in regional and local media engagements

6. Assessment:

- a. Define Metrics:
 - 1) Frequency of access divided by the total number of weekly media hits across all media platforms.
 - a) Army Medicine Homepage
 - b) Army Medicine SharePoint Portal (AMP)
 - c) DCOMM SharePoint Portal
 - d) Social Media Platforms
 - 2) Frequency of request of the plan divided by the total number of requests for information processed within DCOMM
 - 3) Track Army Strategy 2020 requests for information
- b. Information System: Strategic Management System (SMS)
- c. Frequency: Conduct assessment on a quarterly basis as a function of our DCOMM quarterly media



analysis and populate the weekly dashboard with requests for information. Trim data to determine efficacy of communication product

- d. Feedback Mechanism: Army Medicine Campaign Assessment and Performance Dashboard (CAP-D)
- e. Staff Proponent: Directorate of Communications

Program 2-2.1 Human Resources – Talent Management

1. Description: Talent management provides an increasing focus in human resource management on the planned and strategic management of employees. Talent management is often focused on senior leaders; however, effective talent management is a connection between human resource development and organizational effectiveness. An effective talent management system must be included into the organization's strategy and implemented in daily processes throughout the organization as a whole. It cannot be left solely to the human resources department to attract and retain employees, but rather must be practiced at all levels of the organization. The strategy must also include responsibilities for line managers to develop the skills of their immediate subordinates.

Activities within talent management include talent acquisition succession planning, assessment, development compensation and high potential management. The AMEDD must engage in talent management that is strategic and deliberate in how they source, attract, select, train, develop, retain, promote and assign Soldiers and Civilian employees throughout the organization at all levels. The outcome of an effective talent management system will consistently uncover benefits in critical economic areas of: revenue, customer satisfaction, quality, productivity, cost, cycle time and market capitalization. The thought process of an effective talent management approach seeks not only to hire the most qualified and valuable employees but also to put a strong emphasis on retaining those employees as well.

2. Objective: Talent Management ensures that Army Medicine attracts, selects, trains, develops, retains, promotes and assigns Soldiers and employees throughout all level of the organization to ensure the best talent is leveraged to serve the enterprise as strategic leaders in the future.

3. Key Task(s):

- a. Identify, attract and select high quality performers by establishing accession criteria for the skills, knowledge and attributes required of future strategic leaders; start the process with mid-grade leaders and work with consultants and AOC tracks to develop and groom future AMEDD leaders.
- b. Identify programs of enhancement. Monitor trends and career shaping opportunities with selection/attendance to ILE, Training with Industry (TWI), Long Term Health Education and Training (LTHET), Senior Service College (SSC), Joint Fellowships, Fellowships, Office of Congressional Legislative Liaison (OCLL). Track progress by trending fills by Corps of key developmental positions such as Command, DCA, DCN, DCCS, Executive and Primary Staff.
- c. Shape strategic environment. Track Nominative Positions and ALPs, Tier 1 Assignments, Joint billets and Special Assignments.
- d. Identify Office of Primary Responsibility (OPR): Chief Talent Officer (CTO).
- e. Identify Office of Collateral Responsibility (OCR): G-1, APPD, HRC, Corps Chiefs, CSM, Consultants, TMO.

4. Measure(s) of Performance:

- a. Nominative positions fully vetted through an objective process with all Corps represented by qualified strategic leaders "on the bench."



- b. Developmental schools and programs filled by the best qualified leaders. The military education policies align with the leader development processes of Army medicine to produce well trained and well rounded strategic leaders.
- c. Tier 1 positions vetted and programmed two years out with potential candidates based on a defined leader development process.
- d. MEL 1 required positions defined corporately and filled with qualified leaders from all Corps. 05A positions filled by qualified leaders with a steady stream of leaders developed for future opportunity.

5. Measure(s) of Effectiveness:

- a. Diversity in 05A assignments
- b. The best talented team of strategic leaders is developed through a clear path process that includes central school selection, and command and strategic staff assignments. Clear path from CPT to General Officer is accepted and codified.
- c. Assignments and programs of enhancement are filled with leaders developed to serve in strategic assignments. Prepares clearly identified candidates for joint, coalition, OSD and other Service assignment opportunities across all Corps.

6. Assessment:

- a. Information System: Strategic Management System (SMS)
- b. Frequency: Quarterly update—various boards publish results one time throughout a FY
- c. Feedback Mechanism: Army Medicine Campaign Assessment and Performance Dashboard (CAP-D)
- d. Staff PropONENT: G1/4/6 Talent Management

Program 2-2.2 Team and Organizational Development Directorate (TODD)

1. Description: Team building enhances our capacity and propels us to a System For Health and provides the platform to enhance our ability to disseminate the Army Medicine message with timeliness and accuracy. Our vision of a future System For Health relies on our current and future leaders and workforce, the AMEDD team's, ability to manage an increasingly complex medical home front and a declining operational demand while maintaining the mental and physical agility to remain responsive to future missions, and the ability to disseminate the Army Medicine message with timeliness and accuracy. Organizational Development (OD) is an application of behavioral science to organizational change. It encompasses a wide array of theories, processes and activities, all of which are oriented toward the goal of improving individual organizations. Generally speaking, however, OD differs from traditional organizational change techniques in that it typically embraces a more holistic approach that is aimed at transforming thought and behavior throughout an entity. Definitions of OD abound, but they are all predicated on the notion of improving organizational performance through proactive activities and techniques. It is also worth noting that organizational development, though concerned with improving workforce performance, should not be mistaken for human resource development. The TODD will deliver this objective by using an expeditionary team of Organizational Development (OD) specialists agile enough to deploy rapidly to organizations or work groups in crisis and able to contract with AMEDD organizations for intentional training designed to have the most effective impact.

2. Goal: Develop (to bring out the capabilities or possibilities of) a more responsive and reliable Army Medicine Workforce fully aligned to strategic goal achievement by developing highly self-aware individuals and engaged teams that respect and leverage diversity to foster a climate in which shared understanding, mutual trust and a common sense of purpose are the standard every single day.



3. Key Task(s) and Programs within Directorate to Accomplish Goals:

- a. Identify Office of Primary Responsibility (OPR): OTSG TODD
- b. Identify Office of Collateral Responsibility (OCR): DCOMM
- c. Identify Primary Action Officer: COL Kristie Lowry

- 1. Team and Organizational Development Directorate (TODD).** Responsible for central tasking management of all team, leader and organizational development activities. Develops liaison relationships with OTSG/MEDOCM One-Staff to rapidly identify AMEDD teams in need of facilitation services as well as collaborate with ONESTAFF to develop internal teams. Coordinates all training, contracting and budgeting. Specializes in aligning strategic messaging of system of health and team & organizational development progress through DCOMM/Marketing. Trains key uniformed staff as Organizational Development Specialists to provide expeditionary support and facilitation for the needs of TSG. Responsible for the development and implementation of IMPACT3, a six month program designed for senior leaders to enhance responsibility, collaboration and influence at the strategic level.
- 2. Center for Organizational Assessment and Change (COACH) –** Collaborate with change leaders, commanders and other AMEDD personnel to deliver support with a portfolio of strategic focused team training and development programs. The products of the portfolio are delivered through a team of Organizational Development (OD) Specialists. OD Teams will deliver specialized training designed to build highly functional and cohesive AMEDD teams that respect and leverage diversity to optimize healthcare delivery and promote health. Services include: Arbinger's Leadership and Self Deception training and Performance at Work Foundations, Spectrum's Temperament Development Workshops that focuses on behavior and the way individuals receive, process and give information, the Begin with the Basics (BwtB) course which examines methods to deliver customer focused service. COACH also assists with conflict resolution, strategic planning and partnering with strategic leaders for planned systemic change (Culture of Trust).
- 3. Center for AMEDD Service Excellence (CASE) –** Conducts site assessment throughout the AMEDD to provide service excellence and assistance in the tenets of facilities improvement, standardization of care experience and customer relations improvements.

4. Measure(s) of Performance:

- a. TODD Trust Survey: Improved leader engagement as measured by iterant TODD trust survey scores (pre-assessment score, post-intervention 30 day score, 6 month and 12 month).
- b. Improved operational performance metrics: decreased EEO, staff turnover, increased targeted recruitment capability MEDCOM Speaks.
- c. Improved staff engagement and trust as measured by survey.
- d. Improvements in all monitored survey data for beneficiary satisfaction including; including MEDCOM Speaks, Army Provider Level Satisfaction Scores.

5. Measure(s) of Effectiveness: Through comprehensive survey(s), measure the following:

- a. Frequency and enthusiasm a service, course or product is recommended
- b. Loyalty
- c. Retention rate
- d. Morale



- e. Positive feedback
- f. Protection of personally identifiable information
- g. Quality of work life (satisfaction with pay, working conditions)
- h. Work effort and commitment (low absenteeism, turnover)
- i. Employee health and safety
- j. Motivation
- k. Organizational image
- l. Employee behavior
- m. Consensus/conflict: Goal and procedural consensus; cohesion (mutual attraction and identification with work group and organization); cooperation within and between units; conflict behavior (work stoppages, protests, flights)
- n. Work and information flows: Work coordination (smooth flow of products, Information between units, few delays and snags); adequacy and quality of information, multidirectional flows
- o. Interpersonal relations: Trust; moderation of status differences (reduced prominence of status symbols and executive perks); openness, honesty of interpersonal communication, acceptance of diverse backgrounds and orientations
- p. Employee involvement: Empowerment; participation in decision making
- q. Resources-quality: Human capital (training, experience of work force); staff reputation; knowledge base; desirability of clients

6. Assessment:

- a. Information System: Will maintain an OTSG and DKO SharePoint site with all data and reports collected
- b. Frequency: Monthly
- c. Feedback Mechanism: Army Medicine Campaign Assessment and Performance Dashboard (CAP-D)
 - 1) Reports supplied or briefed as requested and monthly activity EXSUMs
 - 2) Evaluate organizational performance
 - 3) Assess organizational culture
 - 4) Conduct employee 360 evaluations
 - 5) Assess leadership strengths and weaknesses
 - 6) Assess employee satisfaction levels
 - 7) Evaluate organizational effectiveness
 - 8) Analyze and evaluate companies
 - 9) Survey Methods
 - 10) Focus Groups
 - 11) Interviews
 - 12) Small Group Discussion
 - 13) Performance Analysis –Quantitative, Qualitative
- d. Staff PropONENT: Team and Organization Development Directorate

Program 2-2.3 AMEDD Healthcare Education and Training Enterprise

1. Description: AMEDD Healthcare Education and Training Enterprise is a program that facilitates a force that is trained and educated on healthy activities/lifestyles improves readiness and will contribute to the Army's long term ability to provide healthcare to its beneficiaries. The education and training enterprise will assist the Army with transformation from a healthcare system to a System For Health.



2. Objective: Develop education and training programs / products for the Army that promote the transition to a system of health.

3. Key Tasks:

- a. AMEDD C&S On-boarding program Initial Healthcare to Health lesson plan for all classes
- b. Curriculum Committee Meetings / Program of Instruction updates for course revision
- c. Training Support Package (TSP) for TRADOC wide distribution as Army common core training
- d. Roles and Responsibilities:
 - 1) Identify Office of Primary Responsibility (OPR) - MEDCOM
 - 2) Identify Office of Collateral Responsibility (OCR) – AMEDD C&S
 - 3) Identify Primary Action Officer – LTC Tim Kunding

4. Measure(s) of Performance:

- a. All AMEDD training incorporates personal and enterprise health instruction (Percentage of courses teaching health instruction)

5. Measure(s) of Effectiveness:

- a. Increase System For Health education and training that facilitates a healthier Force
- b. Positive feedback from surveys (Student Assessment Questionnaires; Supervisory feedback)
- c. Reduction in sick call/sick leave use

6. Assessment:

- a. Information System(s) –
 - 1) Training Development Capabilities / Army Training Requirements and Resources System (TDC/ ATRRS)
 - 2) Self Assessment Questionnaire (SAQ) reporting system
 - 3) Composite Health Care System (CHCS)
 - 4) Civilian personnel management system
- b. Frequency - Quarterly
- c. Feedback Mechanism – Campaign Assessment and Performance Dashboard (CAP-D) / Campaign Assessment and Performance Dashboard (CAP-D)
- d. Staff PropONENT: G-3/5/7 Health Care Operations

Program 2-3.1 National and International Medical Engagement Activities

1. Description: International Medical Engagement Activities program supports The Surgeon General's medical engagement intent and the Operational Commander's Theater Campaign Plans, partner with joint, interagency, international community, and host nation capabilities by providing medical forces to conduct health engagement operations. Build relationships that mitigate human suffering by providing appropriate medical capability in support of whole-of-government responses and priorities.

2. Objective: The goal of International Medical Engagement Activities tasks is to enhance diplomacy by participating in and shaping dialogue on military healthcare delivery and individual health in our Army and in the Armies of our partner Nations; by partnering on projects and issues of mutual interest; through active engagements; and by marketing initiatives.



3. Key Tasks:

- a. UP CJCSI 2700.01, manage AMEDD participation in North Atlantic Treaty Organization (NATO) medical standardization activities. Key Tasks include:
 - (1) Provide representation to participate in the NATO Medical Standardization Working Group and the NATO Medical Standardization Board (twice annually each).
 - (2) Process NATO standardization documents for ratification by DoD stakeholders.
 - (3) Assist US Army representatives to other NATO Medical Working Groups, Expert Panels and Expert Teams with issues relevant to their participation in their respective groups, panels and teams.
- b. Coordinate and advise on geographic (regional and country specific) medical engagement activities as required. Includes country or COCOM/ASCC requested engagement activities to include Medical Readiness Training Exercises and Mobile Training Teams (MEDRETE and MTTs). This operational objective includes oversight of Information and Data Exchange agreements managed and executed by the US Army Medical Research and Materiel Command ; the Foreign Military Sales Program executed by the International Logistics Office, US Army Medical Materiel Agency; and Partnership Program relationships and activities.
- c. Manage and maintain oversight of international affiliations to include requirements with the Foreign Liaison Officer Program, Military Exchange Officer Program, and Engineer and Scientist Exchange Officer Program, as well as Defense Attaché offices at foreign embassies and foreign military medical departments as necessary. Specific task is to serve as Contact Officer (UP AR 380-10) for 3 Foreign Liaison Officers attached to the OTSG HQ.
- d. Support the Foreign Visit Program for Army OTSG National Capital Area Region international visitors. Activities include assurance of diplomatic authority (FVR system), visit planning and coordination, and, multi-agency background development, submission and presentation to TSG and/or other key OTSG leaders. Visits supported include Distinguished Visitor Orientations and COCOM hosted visits.
- e. Provide interagency coordination and consultation for issues involving DoD MTF medical care to foreign nationals. Specific scenarios involve the Secretarial Designee Program, Reciprocal Health Care Agreement implementation, incidental care in exceptional situations, and requests for medical waiver for international military students and their dependents.

4. Measure(s) of Performance:

- a. Numbers of NATO Meetings attended and documents processed
- b. Engagement activities
- c. Strategic, operational and subject matter exchanges and visits
- d. Network of Attaché and foreign military medical department contacts
- e. Number of medical International Military Education and Training (IMET) slots filled

5a. Measure(s) of Effectiveness: International Engagement Activities

- a. Increase the relative change in the number of engagement activities (multi- and bi-lateral) with a target country/coalition where Expand Diplomacy (ED) efforts actively promoted support for increased engagement.
- b. Increase in the number and type of COCOM/MEDCOM medical engagements within a COCOM areas of responsibility (AOR) that increase access and security cooperation.
- c. Increase in number and type of OTSG-level engagements with partner-nation counterparts.



6a. Assessment:

- a) The Office of Primary Responsibility (OPR) and Office of Coordinating Responsibility (OCR) is OTSG International Programs.
- b) Current Primary Action Officer is Mr. Ken Wade, International Medical Programs Coordinator.
- c) Information System Utilized: TBD
- d) Frequency: Annually
- e) Feedback Mechanism: Theater Security Cooperation Management Information System (TSCMIS)
 - 1) Report from AMEDD NATO Working Group, Expert Panel and Team representatives on approved NATO Standardization Agreements and Allied Medical Publications
 - 2) Report from AMEDD MSCs on signed/renewed Data Exchange Agreements and other agreements authorizing/codifying information exchange and collaboration between the AMEDD and a Foreign Partner.
 - 3) Report from MEDCOM International Agreements Officer (SJA) on international agreements signed or implemented during the reporting period.

5b. Measure(s) of Effectiveness: International Engagements

- a. Increase in the relative change in the number of regional and country Specific medical engagement activities in countries/areas where ED activities targeted engagement.
- b. Increase in the number and type of medical engagements from COCOM areas of responsibility (AOR) that increases access and security cooperation.
- c. Increase in number and type of OTSG-level engagements with partner-nation counterparts.

6b. Assessment:

- a. The Office of Primary Responsibility (OPR) and Office of Coordinating Responsibility (OCR) is OTSG International Programs.
- b. Current Primary Action Officer is Mr. Ken Wade, International Medical Programs Coordinator.
- c. Information System Utilized: TBD
- d. Frequency: Quarterly
- e. Feedback Mechanism:
 - 1) Report from ONESTAFF Country/Regional Desk Officers on executed activities within their respective AORs.
 - 2) Report from AMEDD MSCs on executed activities within their respective geographic and programmatic areas of responsibility.
 - 3) Report from AMEDD International Programs on HQ executed activities during the reporting period.

5c. Measure(s) of Effectiveness: International Affiliations

- a. Increase in the relative change in the number of direct engagement activities with Defense Attaches, Foreign Liaison Officers, and Foreign Military Medical Department leaders during the reported period.
- b. Increase in the number and type of medical engagements from COCOM areas of responsibility (AOR) that increases access and security cooperation.
- c. Increase in number and type of OTSG-level engagements with partner-nation counterparts.

6c. Assessment:

- a. The Office of Primary Responsibility (OPR) and Office of Coordinating Responsibility (OCR) is OTSG International Programs.
- b. Current Primary Action Officer is Mr. Ken Wade, International Medical Programs Coordinator.



c. Information System Utilized: TBD

d. Frequency: Quarterly

e. Feedback Mechanism:

- 1) Report from ONESTAFF Country/Regional Desk Officers on executed activities within their respective AORs.
- 2) Report from AMEDD MSCs on executed activities within their respective geographic and programmatic areas of responsibility.
- 3) Report from AMEDD International Programs on HQ executed activities during the reporting period.

6d. Measure(s) of Effectiveness: Foreign Visits

- a. Increase in the relative change in the number of Foreign Visits received at AMEDD organizations during the reported period.
- b. Increase in the number and type of medical engagements from COCOM areas of responsibility (AOR) that increases access and security cooperation
- c. Increase in number and type of OTSG-level engagements with partner-nation counterparts.

6e. Assessment:

- a. The Office of Primary Responsibility (OPR) and Office of Coordinating Responsibility (OCR) is OTSG International Programs.
- b. Current Primary Action Officer is Mr. Ken Wade, International Medical Programs Coordinator.
- c. Information System Utilized: Security Policy Automation Network
- d. Frequency: Quarterly
- e. Feedback Mechanism: Report from ONESTAFF and AMEDD MSC G/S-2 Security Officers on Approved Foreign Visits within their respective geographic and programmatic areas of responsibility.

Program 2-3.2 National and International Medical Training

1. Description: National and International Medical Training program conducts medical engagement activities with partner nation military medical departments in order to co-develop mutually beneficial capabilities and capacities to address shared military medical interests and issues.

2. Objective: The goal of National and International Medical Training is to build international partner nation military medical capability/skill, even as available USG and national defense resources becomes increasingly constrained, by offering Professional Military Education and Technical training seats in Army Medical Department (AMEDD), Academy of Health Sciences (AHS), Medical Education and Training Campus (METC), Defense Medical Readiness Training Institute (DMRTI) and other USA Medical Courses to those nations seeking to participate in the offered training.

3. Key Tasks:

- a. The Office of Primary Responsibility (OPR) and Office of Coordinating Responsibility (OCR): OTSG International Programs.
- b. The current Primary Action Officer: Mr. Keith Charter, International Medical Programs Training Specialist.
- c. Key Tasks include:
 - 1) Representative for Department of the Army Headquarter, Office of the Surgeon General and US Army Medical Command on all DoD Security Cooperation and Assistance Programs which are for medical training



- 2) Medical training subject matter expert at annual Combatant Commands Security Cooperation Education and Training Working Group (SCETWG).
- 3) Quota manager responsible for confirming International Military seat requests in Defense Security Assistance Management System (DSAMS).
- 4) Reservation input into Army Training Requirements and Resources System (ATRRS) seat requests confirmed for attendance at medical courses.
- 5) Review, analyze and recommend policy changes to comply with US Congressional, Department of State and DoD mandates.
- 6) Provide advice and leadership in managing and assessing AMEDD organizations and agencies participating in DoD Security Assistance Program.
- 7) Medical training Liaison Officer for the MEDCOM between Combatant Commands, Defense Security Cooperation Agency (DSCA), US Army Security Assistance Command, US Army Training and Doctrine Command (TRADOC), US Air Force and US Navy.

4. Measure(s) of Performance:

- a. Participation at Army Service Component Command (ASCC) Theater Security Cooperation Conference (TSCC)
- b. Participation at Combatant Command (COCOM) Security Cooperation Education and Training Working Group (SCETWG)
- c. Security Assistance Training Field Activity (SATFA) training
- d. Collaboration with academy Health Science (AHS) International Military Student Office (IMSO) and other Army Medical Department (AMEDD) IMSO

5. Measure(s) of Effectiveness:

- a. Continued enrollment in USA Medical Courses
- b. Successful completion in enrolled training
- c. Re-integration in to nation military
- d. Increased courses available to international military
- e. Military Articles and Services List updated annually
- f. Tuition charges updated at least bi-annually

6. Assessment:

- a. Information System Utilized:
 - 1) Defense Security Management Assistance System (DSAMS)
 - 2) Security Assistance Network (SAN)
 - 3) Army Training Requirements and Resources System (ATRRS)
 - 4) Military Articles and Services List (MASL)
- b. Frequency: Annual review for decrease/increase in quota in relation to enrollees.
- c. Feedback Mechanism: Random survey

Program 2-3.3 Ambassador Program

1. Description: The Army Medicine Ambassador Program is a strategic engagement initiative and formal program to tell the Army Medicine, Army Health and Army Readiness story. It consists of designated or invited Ambassadors (Tier I, II, III) that are in positions of influence or command. The Army Medicine Ambassador is a key messenger and promotes the initiatives of The Surgeon General and the command as a whole that re-



late to health and healthcare. In turn, these leaders are regularly updated on Army Medicine's strategic themes and messages and are expected to share with target audiences, organizations and/or groups.

2. Objective: Army Medicine Ambassadors are the recognizable champions of Army Medicine, Army Health and Army Readiness through the use of a three tier system:

- Tier I (Strategic)
- Tier II (Operational)
- Tier III (External to the organization)

3. Key Tasks:

- a. Staff, synchronize and standardize Army Ambassador Program as an AM 2020 Strategic Initiative; Executive Services (ES) established as Office of Primary and Coordinating Responsibility (OPR/OCR).
- b. Develop working group, charter, OPORD for long-term sustainment and success of program.
- c. Develop training, tool kit, online presence; develop regular information distribution/feed through traditional methods and social media; utilize .mil capability to keep information current: Established .mil site: <https://www.us.army.mil/suite/page/22>
<https://www.milsuite.mil/book/groups/army-medicine-ambassador-program>
- d. Deliver Army Ambassador Program standards to Regional Medical Commands and Major Subordinate plans, providing consistent, predictable amounts of current and reliable information to best tell the Army Medicine Story.
- e. Develop and strengthen relationships and mutually beneficial partnerships that result in improved collaboration, communications, coordination and understanding of Army Medicine in the context conveyed among internal and external audiences.
- f. Promote local community understanding of Army Medicine, Army Health and Army Readiness & Resiliency.

4. Measure(s) of Performance:

- a. 100 Army Medicine Ambassadors are formally designated and committed to be the recognizable champions of Army Medicine, Army Health and Army Readiness and Resiliency for two-year terms (or for the term of the current command/assignment)
- b. 100% of the Command understands they are each an Army Medicine Ambassador and can access current Army Medicine key documents and information portals
- c. Track and trend social media interest/followers/re-tweets, media queries and requests for information

5. Measure(s) of Effectiveness:

- a. Survey other ASCCs and DRUs and assess their knowledge of Army Medicine, Army Health and Army Readiness (before and after)
- b. Increasing trends in followings, re-tweets, media queries and requests for information

6. Assessment:

- a. Information System: Strategic Management System (SMS)
- b. Frequency: Quarterly, Annually
- c. Feedback Mechanism: Direct from engaged constituency (online surveys – think ICE), Campaign Assessment and Performance Dashboard (CAP-D), Council of Colonels, and General Officer Steering Committees
- d. Staff PropONENT: Executive Services



Program 2-3.4 Medical Research and Development Program

1. Description: The Medical Research and Development Program oversees Research, Development, Testing, & Evaluation (RDT&E) efforts within the Command, and provides a means for professional education for professional staff within the DOD. Of significant note are four US Army Medical Research and Materiel Command Special Foreign Activity medical research units located in Germany, Kenya, Thailand and most recently, the Republic of Georgia. These laboratories are collaborative efforts between MRMC and the host country that reinforce the affiliation between our countries and serve as important medical activities that research endemic diseases and advance our respective capabilities.

2. Objective: By establishing a formal infrastructure for RDT&E within the MTF System, such as the Medical Research and Development Program, development, initiation and completion of needed research can be expedited.

3. Key Tasks:

- a. Establishment of RDT&E Infrastructure within selected MTF
- b. Roles and Responsibilities:
 - 1) Identify Office of Primary Responsibility (OPR): MRMC PA(R&T)
 - 2) Identify Office of Collateral Responsibility (OCR): MRMC PAA
 - 3) Identify Primary Action Officer: Dr. Keith Vesely

4. Measure(s) of Performance:

- a. Decrease time it takes to initiate and complete medical research protocols by 25%
- b. Increase the amount of RDT&E-funded research at MTF by 10%
- c. Prioritize funding for research in order to discover or revise facts, theories and applications

5. Measure(s) of Effectiveness:

- a. Increase in research programs associated with civilian counterparts
- b. Enhanced non-combat related discoveries that were conducted through focused research
- c. Increase in programmed monies that led to significant contributions for System For Health

6. Assessment:

- a. Information System (Strategic Management System [SMS]): N/A
- b. Frequency (Quarterly): Quarterly
- c. Feedback Mechanism (BSC, Council of Colonels, GOSC): GOSC
- d. PropONENT: US Army Medical Research and Materiel Command



Annex C Line of Effort (LOE) 3 Improve Stamina Programs & Projects

Program 3-1.1 Implement the Performance Triad (Activity / Nutrition / Sleep)

1. Description: Army Medicine's operational approach to improve Soldier and Family health and stamina will focus on the Army Medicine Performance Triad of Activity, Nutrition and Sleep Management (ANS). The Performance Triad will develop MEDCOM strategy and action plans leveraging programs, initiatives and Subject Matter Experts within Army Medicine, Department of Defense, and the civilian sector in order to improve stamina (fitness, resiliency, readiness and health) of Soldiers, Families and Veterans. This will result in healthy and resilient Soldiers, Families and Veterans with life skills and habits that promote health, life-fitness and readiness.

2. Objective: The objective of the Performance Triad (ANS) is to improve stamina (fitness, resiliency, readiness and health) of Soldiers, Families and Veterans. Specific objectives include increasing the percentage of the beneficiary population with healthy weight (BMI 18.5 – 24.9), increasing performance on the Army Physical Fitness Test (APFT), decreasing the medically non-deployable population, and decreasing the prevalence of hypertension, hypercholesterolemia, and diabetes.

3. Key Tasks:

- a. **Activity**-Through education, programs and policy, positively change the mindset of Army Family members (Soldiers, Retirees, Family Members, Veterans, and DoD Civilians) to make active lifestyle choices in their Lifespace. The end state will result in Army Family members who consistently engage in healthy activities that Maintain, Restore and Improve stamina, health, and resilience throughout the lifespan. There will be three lines of effort: 1) Education-aimed at dissemination of evidence-based information and educational products, 2) Programs-aimed at promoting and enhancing current internal initiatives and leveraging external initiatives, and 3) Policy-aimed at ensuring changes are implemented into policy for enduring effect.
- b. **Nutrition**-Develop a nutrition strategy that leverages programs, initiatives and Subject Matter Experts within the AMEDD, DoD and civilian sector in order to empower, motivate, incentivize and energize beneficiaries to make the healthy choice the easy choice thus supporting stamina. There will be four lines of effort: 1) Surveillance-aimed at improved surveillance capability to better report on nutrition data to inform policy, 2) Care-aimed at optimizing the care system to effectively prevent, identify, track, treat and manage nutritional aspects of health, 3) Environment-aimed at improving the nutritional environment on Army installations, and 4) Education/Communication-aimed at improved standardization, synchronization and quality assurance of nutritional communication and education.
- c. **Sleep**-Through education, training and indicated treatment, change the mindset and culture in the Army to maintain, restore, and improve sleep duration and quality so that individuals will achieve optimal cognitive performance, emotional well-being, and physical readiness. There will be three lines of effort: 1) Universal-aimed at education of the force on healthy sleep habits, 2) Selective-aimed at leader education designed to improve sleep hygiene to improve performance and safety, and 3) Indicated-aimed at the percent of the population requiring further evaluation and treatment.

4. Measure(s) of Performance:

- a. Percentage of Armed Forces Health Longitudinal Technology Application (AHLTA) encounters



- recording body mass index (BMI)
- b. Performance Triad Primer published
- c. Performance Triad Pilot conducted

5. Measure(s) of Effectiveness:

- a. Increase percentage of beneficiary population with healthy weight (BMI 18.5 – 24.9)
- b. Increase APFT Performance
- c. Increase demonstratable control of hypertension, hypercholesterolemia, and diabetes

6. Assessment:

- a. Information System Utilized: BMI and incidence of hypertension, hypercholesterolemia and diabetes will be tracked using AHLTA. APFT data will be monitored through DTMS.
- b. Frequency Reviewed / Updated: Annual review of BMI, and prevalence of hypertension, hypercholesterolemia and diabetes. Bi-annual review of APFT data (this should already be occurring at the unit level). Primer will be reviewed every 2 years and updated as indicated (based on current best evidence).
- c. Feedback Mechanism: APFT data is tracked as part of the Unit Status Report and reported up the chain of command. Clinical data regarding BMI, hypertension, hypercholesterolemia and hypertension will be tracked at the MTF level at least annually through ad hoc or established reporting mechanisms.
- d. Staff Propopent: G-3/5/7 Health and Wellness

Program 3-1.2 Promote Psychological Resilience

1. Description: Psychological resilience is the ability to bounce back from psychological stressors and function effectively under stressful conditions. MEDCOM supports Army Readiness and Resiliency Campaign objectives by providing quality behavioral health (BH) care. This includes integrating and embedding behavioral health expertise and programs into operational units, the community, and the Medical Home.

2. Objective: Comprehensive Soldier and Family Fitness (CSF2) is a program that broadens the assessment and training of every member of the Army beyond standard physical and technical abilities. The training equips individuals with valuable life skills to help them better cope in stressful situations, bounce back from adversity, and avoid self-defeating behaviors. The mission of CSF2 is to increase the physical and psychological health, resilience and enhanced performance in Soldiers, their Families, and Department of the Army (DA) civilians. The expected outcome (end state) is a total Army team of physically healthy and psychologically strong individuals whose resilience and total fitness enables them to thrive in the military and civilian sector and meet a wide range of operational demands.

3. Key Task(s):

- a. Master Resilience Trainer requirements (MRT) are increased to: one 8R certified MRT per company, and one MRT in organizations with more than 250 assigned civilian personnel. Additionally, one program manager who is qualified as an MRT level 1 will be assigned collateral duty to each senior command level at each installation.
- b. Commanders will only select individuals to attend the MRT course who possess excellent communication and presentation skills, meet the standards of AR 600-9, AR 350-1, exercise effective coping mechanisms and display the traits of resilience. MRTs will have a 2-year stabilization period upon course completion.



- c. FORSCOM and TRADOC are directed to conduct a 90-day pilot program to examine the efficacy of formal resilience training conducted during in-processing at new duty stations.
- d. TRADOC is responsible to maintain an MRT Level 1 training capability for up to 1800 personnel annually, and for establishing an MRT Level 2 training capability for up to 80 personnel annually.
- e. CSF2-PREP will chair a performance enhancement execution strategy committee comprised of representatives from CSF2, WRAIR, TRACOD/CAC, PHC, FORSCOM, CSF2-PREP, ARNG, USAR and subject matter experts as needed.
- f. Resilience reporting requirements have been added to the unit status report (USR) for all components in order to measure execution and compliance of CSF2 program requirements.
- g. The updated physical dimension of the Global Assessment Tool (GAT) assesses areas that include Physical Conditioning, Nutrition, Sleep, Tobacco use, Alcohol and Dietary Supplements.

4. Measure(s) of Performance:

- a. Access to Care Standards – Assess enhanced access to care compliance for Behavioral Health appointments per MEDCOM Policy 11-005 (BH 360/CMS).
- b. Behavioral Health follow-up for discharged patients – HEDIS measure capturing percentage of members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who were seen on an ambulatory basis with a BH provider on day of discharge or within 7 or 30-days (CMS).

5. Measure(s) of Effectiveness:

- a. Acute Psychiatric Inpatient hospitalizations (available in M2 and CMS): Number of Soldier inpatient admissions per 1K Soldier beneficiary population (CMS).
- b. Acute Psychiatric Inpatient re-hospitalizations (available in M2 and CMS): Number of Soldiers that had an inpatient readmission within 30-days of initial admission (BH 360).
- c. Longitudinal GAT scores from CSF2 (Proposed Metric)

6. Assessment:

- a. Information System Utilized: CSF2 GAT scores, M2, Strategic Management System/Command Management System; Behavioral Health 360
- b. Frequency Reviewed / Updated: As needed
- c. Feedback Mechanism: CSF2, Behavioral Health Service Line
- d. Staff PropONENT: G-3/5/7 Health Care Delivery

Program 3-1.3 Promote Oral Health

1. Description: Oral health is important for overall resilience, readiness, and quality of life. Dental care visits provide additional touch points for assessing unhealthy behaviors such as tobacco/alcohol use, monitoring chronic health problems, identifying unhealthy nutrition choices and promoting healthy activities and behaviors.

2. Objective: The goal of this objective is to promote improvement and sustainment of Dental/Medical readiness and oral health through clinical and community oral health promotion and disease prevention programs. Specific goals include decreasing the percent of Soldiers in Dental Readiness Class (DRC) 3 and 4, increasing the percent of Soldiers in DRC 1, and increasing the percent of beneficiaries enrolled in the TRICARE Dental Program (TDP) and the Retiree Dental Program (TRDP) that utilize preventive dental services annually.



3. Key Tasks:

- a. Conduct screenings and exams to evaluate risk for hypertension, orofacial injury, pathology, and to detect oral diseases. Implement high caries risk treatment protocols, and provide information on modern evidenced-based dental treatment and oral disease prevention strategies to include: tobacco cessation referral, alcohol use and awareness, nutritional counseling and oral hygiene techniques, appropriate medical referrals to Physicians regarding medical findings.
- b. Create an environment that promotes healthy lifestyles and healthy choices for Soldiers and Family members by integrating oral health promotion and disease prevention information into all related Army Medical Department (AMEDD) and Army community programs. Desired changes include: dental representation on the Community Health Promotion Council (as per AR 600-63); increasing Family member enrollment and utilization of the TRICARE Dental Program; advocating for community water fluoridation; detecting and reporting Family violence; providing oral health educational resources for use by healthcare providers (obstetrics, pediatric primary care, dieticians, and community health nurses); and providing oral health educational resources to installation organizations such as Family Readiness Groups (FRGs), Army Substance Abuse Program (ASAP), Army Child, Youth and School Services, Army Community Service programs, Department of Defense Dependent Schools and retail outlets on post.
- c. Integrate oral disease screening, prevention counseling and indicated dental referrals into routine medical visits for pediatric, obstetric and diabetic patients, as well as for patients with cardiovascular disease.
- d. Enhance unit readiness and maximize human resources by holding Soldiers (all components), accountable for maintaining their dental readiness. This includes avoiding harmful habits, obtaining an annual dental examination, seeking treatment when they experience signs of a problem and completing all necessary treatment as quickly as possible.

4. Measure(s) of Performance:

- a. Percent of beneficiaries enrolled in the TRICARE Dental Program (TDP) and the Retiree Dental Program (TRDP) that utilize preventive dental services annually.

5. Measure(s) of Effectiveness:

- a. Percent of Soldiers in Dental Readiness Class (DRC) 3 and 4 (All Components)
- b. Percent of of Active Component Soldiers in DRC 1
- c. Percent of Army National Guard Soldiers in DRC 1 and 2.
- d. Percent of Army Reserve Soldiers in DRC1 and 2.

6. Assessment:

- a. Information System Utilized: MEDPROS
- b. Frequency Reviewed / Updated: Monthly / daily with a data feed from the Dental Command's (DENCOM) Corporate Dental System (CDS) which collects data in real time feeding the MEDPROS every 24 hours.
- c. Feedback Mechanism:
 1. Commanders can view the updated Unit Medical and Dental Readiness data through MEDPROS.
 2. Monthly Dental Readiness Report to FORSCOM, TRADOC, USAR, NGB Surgeon's Office Chief Dental Officer(s).
- d. Staff Proponent: G-3/5/7 Health Care Delivery



Program 3-1.4 Develop Resources for Health

1. Description: Improving stamina through a System For Health will likely require revolutionary change in the way resources are forecasted, allocated, executed and managed. Current resourcing models incentivize illness care in brick and mortar facilities and are not generally based on maintaining and improving health in the Lifespace.

2. Objective: The goal of this program is to provide ongoing effective resource management for initiatives that support stamina while also focusing considerable thought and effort to research, develop, coordinate and implement novel resourcing models. Specific goals are to implement a process to systematically investigate alternate resourcing models, increase the overall proportion of resources (fiscal and manpower) allocated for health, develop incentives for a System For Health, monitor health programs for return on Investment and conduct cost benefit analyses for all unfunded requests.

3. Key Tasks:

- a. Revolutionize resource allocation through the development of a resourcing strategy that focuses on and rewards health outcomes versus procedural outputs.
- b. Develop creative incentives for a System For Health. For example, develop metrics to incentivize MTF Commanders to achieve the goals of the ANS initiatives.
- c. Identify the fiscal and manpower resource requirements for all ANS initiatives.
- d. Perform cost benefit analysis of initiatives to determine risk trade-off and bill-payer strategy.
- e. Develop work-plans and spend plans to manage initiatives in order to perform variance analysis and ensure execution of resources.

4. Measure(s) of Performance:

- a. Percent increase in overall resources (fiscal and manpower) allocated for health
- b. Return on Investment of Initiatives Implemented
- c. 100% of cost benefit analysis completed for unfunded requests
- d. 100% of work-plan and Spend Plans are executed

5. Measure(s) of Effectiveness:

- a. Process is implemented to systematically investigate alternate resourcing models
- b. Incentives and indicators of success are developed that focus MTF efforts and performance on the goals of ANS initiatives.
- c. Fiscal and manpower requirements are identified and documented through work plans and spend plans.
- d. Cost management and execution reviews are conducted to ensure stated outcomes and goals of ANS initiatives are being met.

6. Assessment:

- a. Information System Utilized: GFEBS, DMHRSi, ATAAPS, MEPRS, AHLTA. These information systems are used to identify execution of stated tasks through review of input of timesheets (DHMRSi and ATAAPS) and financial execution against ANS WBS Elements in GFEBS. MEPRS and AHLTA will be used to monitor clinical outputs of ANS initiatives.
- b. Frequency Reviewed / Updated:
 - 1) Annual identification of fiscal and manpower requirements in support of ANS initiatives. Requirements are predicted through a functional manpower model and documented in a Work Plan.



- 2) Cost benefit analysis is conducted for all ANS initiatives IAW with the annual cycle. Semi-annual review of ANS initiatives will be conducted to verify benefits hypothesized are achieved.
 - 3) Quarterly cost management and execution of ANS initiative work plans and spend plans are performed.
 - 4) Semi-annual review of execution is performed to determine the amount of financial reward that is due to MTF Commanders for achieving ANS goals.
 - 5) Semi-annual review and analysis of the amount of resources allocated for health versus the traditional sick care model.
- c. Feedback Mechanism:
- 1) Financial and manpower execution will be monitored monthly through GFEBs reporting by ANS initiative WBS Element.
 - 2) Quarterly In-Progress Reviews of ANS initiatives.
 - 3) Resource Summary documentation of financial incentives earned by MTF Commanders.
- d. Staff PropONENT: G-8 /9 Resource Management

Program 3-2.1 Develop Infrastructure for Health

1. Description: The infrastructure for health includes installations, facilities and organizations that are designed to promote health. The built environment, or the surroundings we create for the places we live, work, shop impacts the decision we make to live a healthy lifestyle. The AMEDD can impact this directly for facilities and organizations under its control but it also has important consultative and advocacy roles for infrastructure outside its direct control.

2. Objective: The objective of developing an infrastructure for health is to proactively influence the development of installations and organizations that promote health. This will be done by increasing the percentage of installations with a mature Community Health Promotion Council, increasing the percentage of health portals and touch points that are well-integrated into the community and Medical Homes, increasing the percentage of installations meeting CACHE standards for healthy living communities, and working with community planners and leaders to design and promote healthy built environments.

3. Key Tasks:

- a. Work with HQDA G1 to implement effective, standardized Community Health Promotion Councils (CHPCs) through policy, resourcing, program guidance and oversight.
- b. Implement effective, standardized Army Wellness Centers (AWCs) through policy, resourcing, program guidance and oversight.
- c. Pilot, evaluate, and refine the “Creating Active Communities and Healthy Environments” (CACHE) toolkit. If determined successful by Campaign Assessment and Performance Management, recommend implement the program Army-wide.
- d. Partner with community planners and leaders to design and promote healthy Built Environments.

4. Measure(s) of Performance:

- a. Percentage of installation community planning initiatives that have formal AMEDD involvement
- b. Standardized, validated CACHE toolkit

5. Measure(s) of Effectiveness:

- a. Percentage of installations with a mature CHPC process as measured by USAPHC Structure Process Evaluation Tool/Program Status Report



- b. Percentage of installations with standardized Army Wellness Centers that are well-integrated into the community and Medical Homes
- c. Percentage of Army installations meeting CACHE standards for healthy living communities

6. Assessment:

- a. Information System Utilized: Public Health Program Status Report, SMS
- b. Frequency Reviewed / Updated: Quarterly
- c. Feedback Mechanism: Portfolio and Program IPRs, Campaign Assessment and Performance Dashboard (CAP-D), Status Reports
- d. Propopent: Public Health Command - Health Promotion and Wellness

Program 3-2.2 Manage Occupational & Environmental Health Threats

1. Description: Healthy community and work environments are a key component for health. Nearly one quarter of all deaths worldwide can be attributed to environmental factors including exposure to hazardous substances in the air, water, soil and food; arthropod borne disease; natural and man-made disasters; physical safety hazards; and the built environment.

2. Objective: The goal of this sub-objective is to manage occupational and environmental risks through consistent monitoring and effective prevention, mitigation and response activities. Specific goals are to develop systems and processes to provide a comprehensive Common Operating Picture of public health threats and risks, decrease morbidity and mortality from occupational and environmental hazards, and reduce costs and regulatory violations resulting from inadequate controls (FECA claims, disability payments, OSHA violations, etc.).

3. Key Tasks:

- a. Develop and maintain an infrastructure to conduct comprehensive health surveillance, to include infectious diseases, arthropod borne diseases, toxic substances and physical hazards.
- b. Develop, implement and oversee programs and capabilities to detect, identify and quantify occupational hazards; assess and communicate health risks; and manage/mitigate risk of exposures .
- c. Develop and maintain an infrastructure to respond to occupational, environmental (industrial and arthropod borne disease) and other public health emergencies.
- d. Develop and maintain the capability to conduct public health information measures for public health issues and emergencies.
- e. Develop and maintain partnerships to prevent, mitigate and respond to public health issues.

4. Measure(s) of Performance:

- a. Accomplishing scheduled assessments
- b. Medical Surveillance Exam completion rates
- c. Education and Training completion
- d. Resource availability
- e. DRSi report timeliness and completeness

5. Measure(s) of Effectiveness:

- a. Comprehensive Common Operating Picture of public health threats
- b. FECA claims costs, lost time days



- c. Regulatory violations (OSHA and others)
- d. Press activity on occupational and environmental threats and outcomes

6. Assessment:

- a. Information System Utilized: DOEHRS-IH, DOEHRS-HC: MOP 5a; AHLTA:MOP5b; OH Clinic and MTF Training databases: MOP 5c, Disease Reporting System-internet (DRSi)
- b. Frequency Reviewed / Updated: MOP 5a, DOEHRS annually and with new hazard/exposure; MOP 5b; annually and with post-exposure assessment; MOP 5c: monthly/new personnel, DRSi is re-viewed daily,
- c. Feedback Mechanism: Occupational Health Program Status report(OHPSR), Environmental Health Program Status Report (EHPSR), OIP, PHC Portfolio IPRs, DRSi Reports, Campaign Assessment and Performance Dashboard (CAP-D)
- d. Staff Propopent: G-3/5/7 Health and Wellness

Program 3-2.3 Clinical and Community Preventive Services

1. Description: Evidence-based clinical and community preventive services are a key component of a System For Health. Preventive Services consist of screening tests, counseling, immunizations or medications used to prevent disease, detect health problems early, or provide people with the information they need to make good decisions about their health. They are effective in reducing death and disability, and are cost-effective or even cost-saving. While preventive services are traditionally delivered in clinical settings, some can be delivered within communities, units, work sites, schools or homes. Clinical preventive services can be supported and reinforced by community-based prevention, policies and programs. Technology is an important enabler in expanding preventive services into the Lifespace.

2. Objective: The goal of this program is to ensure that prevention-focused health care and community prevention efforts are available and integrated across the System For Health. Specific goals are to decrease morbidity, mortality, and disability rates; decrease the prevalence of hypertension, hypercholesterolemia, and diabetes; increase the use of recommended clinical preventive services; increase immunization rates; and increase compliance with Healthcare Effectiveness Data and Information Set (HEDIS) measures.

3. Key Tasks:

- a. Expand use of health information technology. Use various tools to access and learn about health and prevention and ways they can better manage their health (e.g., personal health records, text reminder services, smart phone applications).
- b. Evaluate incentives for access to clinical preventive services.
- c. Support the implementation of community-based preventive services and enhance linkages with clinical care. Inform patients about the benefits of preventive services.
- d. Train providers (e.g., doctors, nurses, dentists, allied health professionals) to use health information technology to offer patients recommended clinical preventive services as a routine part of their health care.
- e. Establish patient and clinical reminder systems for preventive services (e.g., mailing cards, e-mails, or phone calls when a patient is due for a preventive health service; EHR reminders or cues, chart stickers, vital signs stamps, medical record flow sheets, etc.).
- f. Expand hours of operation, provide child care, offer services in convenient locations (e.g., near workplaces), or use community or retail sites to provide preventive services.
- g. Expand public-private partnerships to implement community preventive services (e.g., school-based oral



health programs, community-based diabetes prevention programs). Create linkages with and connect patients to community resources (e.g., tobacco quit lines), Family support, and education programs.

4. Measure(s) of Performance:

- a. Immunization rates
- b. Health behavior survey results

5. Measure(s) of Effectiveness:

- a. Disease and mortality rates
- b. Prevalence of hypertension, hypercholesterolemia, and diabetes
- c. Compliance with Healthcare Effectiveness Data and Information Set (HEDIS) measures
- d. Incidence of vaccine-preventable diseases

6. Assessment:

- a. Information System Utilized: AHLTA, MEDPROS, SMS
- b. Frequency Reviewed / Updated: Quarterly, seasonal (influenza)
- c. Feedback Mechanism: Reports, IPRs, R&As, GOSCs
- d. PropONENT: Public Health Command - Epidemiology and Disease Surveillance

Program 3-2.4 Leader and Organizational Development

1. Description: “Leader and Organizational Development” is a major focus area of the Stamina line of effort. The program was placed under campaign objective 3-2 with the understanding that it applies to the entire LOE. This program will incorporate operating company principles and develop processes to identify, evaluate, select, and operationalize best practices for programs that improve stamina. It will develop and implement training and leader development initiatives, develop technology solutions, and fund research for individual and organizational stamina.

2. Objective: The goal of this sub-objective is to improve organizational stamina by improving and refining training, leader development, management processes, knowledge sharing and the ability to innovate. Specific goals are leaders and organizations with stamina that are capable of effective sustained and surge operations; organizational infrastructure and processes that support stamina initiatives and programs; and leaders who understand and promote stamina programs and initiatives.

3. Key Tasks:

- a. Incorporate operating company principles into programs that promote individual and organizational stamina.
- b. Develop processes to identify, evaluate, select and operationalize best practices for programs that improve stamina.
- c. Develop and implement training and leader development initiatives for programs that improve individual and organizational stamina.
- d. Develop processes to coordinate AMEDD stamina initiatives with the Army, DoD, interagency partners, and other key stakeholders.
- e. Develop technology solutions to support stamina initiatives and programs.
- f. Fund research on individual and organizational stamina.
- g. Field leader development programs for AMEDD personnel that increase self-awareness, promote deep collaboration, and enhance influence.



4. Measure(s) of Performance:

- a. Number of training and leader development programs incorporating individual and organizational stamina.
- b. Research funding allocated for individual and organizational stamina.
- c. Process to identify and develop technology solutions for individual and organizational stamina.

5. Measure(s) of Effectiveness:

- a. Leaders and organizations with stamina that are capable of effective sustained and surge operations
- b. Organizational infrastructure and processes in place that are effectively supporting stamina initiatives and programs
- c. Leaders who understand and promote stamina programs
- d. Leaders who work toward enhanced self-awareness and recover greater responsibility to engage and align with enterprise strategic goals

6. Assessment:

- a. Information System Utilized: N/A
- b. Frequency Reviewed / Updated: Varies
- c. Feedback Mechanism: IPRs, Reports, Surveys, GOSC, Research funding procedures.
- d. PropONENT: Public Health Command - Strategy and Innovation Office

Program 3-3.1 Promote Tobacco Free Living

1. Description: Tobacco use is the leading cause of preventable death in the United States. Tobacco free living reduces the risk for heart disease, cancers, chronic obstructive pulmonary disease, periodontal disease, asthma and dying prematurely. Tobacco-free living means avoiding all types of tobacco products including cigarettes, cigars, smokeless tobacco, pipes and hookah pipes. It also includes living free from secondhand smoke.

2. Objective: The goal of this program is to substantially decrease tobacco use by changing the Army culture on tobacco. This will reduce morbidity and mortality rates from tobacco-related diseases in Army beneficiaries. A specific program goal is to increase the proportion of MTF campuses and other areas on Army installations that are tobacco-free.

3. Key Tasks:

- a. Engage leaders for setting conditions that promote healthy choices including policies that prohibit the sale and use of tobacco products on Army installations.
- b. Educate individuals on the serious health effects of tobacco use. Conduct community-based education campaigns and standardized, evidence-based smoking cessation programs within the Army Wellness Centers, Medical Homes and Dental Treatment Facilities.
- c. Medical Homes and Dental Treatment Facilities screen and educate individual beneficiaries on the risks associated with tobacco use.

4. Measure(s) of Performance:

- a. Standardized policy and program guidance for tobacco cessation programs.
- b. Installations with fully developed and operational tobacco cessation programs.
- c. Tobacco initiatives introduced into existing governance structures, like the HPRR-C and Health of the Force meeting cycle.



5. Measure(s) of Effectiveness:

- a. Percent of individuals using tobacco products
- b. Morbidity and mortality rates from tobacco-related diseases in Army beneficiaries
- c. Percent of MTF campuses that are tobacco free

6. Assessment:

- a. Information System Utilized: Surveys, AHLTA, Soldier Fitness Tracker (SFT)
- b. Frequency Reviewed / Updated: Varies
- c. Feedback Mechanism: Health Promotion and Risk Reduction (HPRR-C), CHPC meetings, AWC IPRs, PCMH IPRs
- d. PropONENT: Public Health Command - Health Promotion and Wellness

Program 3-3.2 Prevent Drug Abuse and Excessive Alcohol Use

1. Description: Drug abuse and the excessive use of alcohol run counter to health, stamina, readiness and Army values. Binge drinking and illicit drug use are associated with accidents, suicide, intimate partner violence and risky sexual behaviors, including unprotected sex and multiple sex partners. The AMEDD generally has a supporting, but important role in drug and alcohol abuse prevention and treatment programs.

2. Objective: The goal of this program is for beneficiaries to practice moderation when consuming alcohol and abstinence from illicit drug use. Specific goals include decreasing morbidity and mortality from alcohol and drug related incidents and diseases, decreasing the percent of adults who engage in excessive alcohol use, decreasing DUI rates, decreasing the percent of adults requiring substance use disorder treatment, decreasing recidivism rates for Soldiers completing alcohol treatment programs, decreasing the incidence of drug test failures.

3. Key Tasks:

- a. Partner with the installation Army Substance Abuse Program and the Community Health Promotion Council (CHPC) to educate leaders and beneficiaries on the risks associated with excessive alcohol use and drug abuse.
- b. Implement drug and alcohol counseling into clinical encounters and monitor provider compliance.
- c. Develop ways to have the AMEDD set the example for personal and organizational behavior in this area.

4. Measure(s) of Performance:

- a. Enrollment in Residential Treatment Facilities
- b. Number of Army Substance Abuse Program Encounters

5. Measure(s) of Effectiveness:

- a. Percent of individuals who engage in excessive alcohol use
- b. Percent of individuals referred to substance use disorder treatment
- c. Recidivism rates for Soldiers completing alcohol treatment programs
- d. DUI rates
- e. Drug test failures/Positive Urinalysis
- f. Clinical scales (Proposed Metrics pending Behavioral Health Data Portal Proliferation).



g. Inpatient Admissions per population (Proposed Metric): Number of inpatient admissions for substance abuse per 1,000 patients or beneficiary population.

6. Assessment:

- a. Information System Utilized: M2, Behavioral Health Data Portal
- b. Frequency Reviewed / Updated: As Needed
- c. Feedback Mechanism: Army Substance Abuse Program IPRs and reports, CHPC meetings, HPRR-C meetings/TAPS
- d. Staff Propopent: G-3/5/7 Health and Wellness

Program 3-3.3 Promote Responsible Sexual Behavior

1. Description: Sexually transmitted infections (STIs), including HIV, continue to occur in Soldiers and other Army beneficiaries. Antibiotic resistance in STIs is an increasing concern. There are approximately 19 million new cases of STIs in the United States each year and almost half of these occur in young people ages 15 to 24. More than one million people in the United States are estimated to be living with HIV infection, and more than 50,000 people become infected annually. This program will monitor STI rates for Army beneficiaries. It will develop targeted educational strategies for Soldiers, leaders and beneficiaries to encourage responsible sexual behavior. It will leverage the Medical Homes to support educational efforts and access to reproductive health services. It will also provide a central repository of current, evidence-based resources to aid MTFs and leadership in their efforts to reduce behavioral risk factors that contribute to high rates of STIs and unplanned pregnancy.

2. Objective: The goal of this program is to develop, implement and monitor initiatives that promote healthy sexual health practices. Specific goals include increasing appropriate sexual health behavior, decreasing STI and STI complication rates, and decreasing the incidence of unplanned pregnancy.

3. Key Tasks:

- a. Develop targeted educational strategies for Soldiers, leaders and beneficiaries to encourage responsible sexual behavior. Strategies include the promotion of prophylaxis use, abstinence and monogamous relationships.
- b. Utilize PCMH to support educational efforts and will provide access to reproductive health services.
- c. Provide a central repository of current, evidence-based resources to aid MTFs and leadership in their efforts to reduce behavioral risk factors that contribute to high rates of STIs and unplanned pregnancy.

4. Measure(s) of Performance:

- a. Standardized policies and programs for providers and beneficiaries.
- b. Installations and MTFs with standardized programs.

5. Measure(s) of Effectiveness:

- a. STI rates (% of adults with a diagnosis of Syphilis, Chlamydia, Gonorrhea within the last 12 months)
- b. Human immunodeficiency virus (HIV) rates
- c. Rates of Condom Use and Incidence of Unplanned Pregnancy (historically captured by the DoD Survey of Health Related Behaviors Among Active Duty Military Personnel, can also be captured through locally generated surveys)



6. Assessment:

- a. Information System Utilized: AHLTA, Disease Reporting System-internet (DRSi)
- b. Frequency Reviewed / Updated: Varies
- c. Feedback Mechanism: DRSi reports, HIV reports, program IPRs, CHPC meetings.
- d. Staff Proponent: G-3/5/7 Health and Wellness

Program 3-3.4 Injury and Violence Free Living

1. Description: Injuries are a leading cause of morbidity and mortality among Army Soldiers and beneficiaries. Injuries contribute considerably to healthcare costs, disability, evacuations from theater, lost duty time, and medical non-deployability. The Army also continues to face domestic violence, sexual violence, and suicide. Injury and violence free living is supported by policies and programs that enhance transportation safety, prevent injuries in the workplace, prevent falls, and prevent violence of all kinds. Injury and violence free living is also supported by community and streetscape design that promotes safety and prevents injuries. An important program element is providing individuals and Families with the knowledge, skills, and tools to make choices that prevent violence and injuries.

2. Objective: The goal of this objective is to enhance readiness by reducing preventable injuries and accidents at home, work and play; reducing domestic, sexual and workplace violence; and reducing hazing, bullying and suicide. Specific goals include decreased injury rates, decreased disability rates, decreased injury medical visits and hospitalizations, improved injury cause coding and analysis, decreased workplace harassment and violence rates, decreased suicidal behavior rates and decreased domestic violence rates.

3. Key Tasks:

- a. Promote adherence to the Army's Physical Readiness Training program.
- b. Evaluate the Army Physical Readiness Test to optimize fitness and reduce injury.
- c. Integrate a certified fitness trainer at the unit level through the Master Fitness Training Program.
- d. Incorporate the American College of Sports Medicine's "Exercise is Medicine" into the Army's Patient Centered Medical Home.
- e. Develop an Injury Prevention/ Human Performance Optimization (IP/HPO) program toolkit to assist brigade physical therapists in implementing evidence based IP/HPO programs in combat brigades.
- f. Evaluate the effect of Musculoskeletal Action Teams on activity and injury in FORSCOM and TRADOC units.
- g. Assess the built environment for promoting physical activity at select Army installations using the Promoting Active Communities tool.
- h. Enhance and standardize the Civilian Employee Fitness Program through implementation for those installations not currently offering the program, increasing accessibility/integration other eligible participants.
- i. Expand access to the Pregnancy Post-Partum Physical Training Program to Family members and DA civilians.
- j. Develop an injury prevention education program for Retirees through AWCs to promote continued healthy behaviors after their transition into retirement.
- k. Partner with Army Family Advocacy Program and Sexual Harassment/Assault Response Prevention Programs to enable healthy violence-free relationships and environments.
- l. Partner with Army Equal Opportunity (EO) Branch to provide leaders with actionable intelligence related to reports of workplace harassment, violence, hazing, and bullying.



m. Provide leaders with periodic analyses of suicide and suicide related behaviors among Soldiers.

4. Measure(s) of Performance:

- a. Percentage units adhering to the APRT
- b. Percentage units with a certified fitness trainer
- c. Percentage CHPCs using standardized injury/violence metrics
- d. Installations completing Promoting Active Communities tool
- e. Participants in Civilian Employee Fitness Program by installation
- f. Installations participating in Pregnancy Post-Partum Physical Training Program
- g. Utilization of Army Wellness Centers by Retirees

5. Measure(s) of Effectiveness:

- a. Rates of Reported Injury
- b. Disability rates
- c. Causes of injury hospitalizations
- d. Accident reports
- e. Rates of Reported Workplace Harassment/Violence
- f. Rates of Reported Suicidal Behavior
- g. Rates of Reported Domestic Violence

6. Assessment:

- a. Information Systems Utilized:
 - 1) Mishap Data Report (MDR) (injury rates and causes)
 - 2) Electronic Medical and Physical Evaluation Board (eMEB/ePEB) (disability rates)
 - 3) Army Behavioral Health Integrated Data Environment (ABHIDE) (suicidal behavior rates)
 - 4) COPS (violence rates)
 - 5) Army Safety. Management Information System – Revised (ASMIS-R) (accident reports)
 - 6) Sexual Assault Prevention and Response Program (SHARP) (workplace harassment data)
 - 7) Data calls (Measures of Performance)
 - 8) Soldier Fitness Tracker (SFT)
- b. Frequency Reviewed / Updated: Quarterly
- c. Feedback Mechanism: Several dashboards are in development, and that method is probably the ultimate goal. In the meantime, reports will have to suffice. SMS could be used to display data if that's the preferred tool right now.
- d. Proponent: Public Health Command - Epidemiology and Disease Surveillance



Annex D - Campaign Assessment & Performance Management

What tells us we have moved towards a System for Health?

To determine if we are accomplishing our objectives, we have implemented a comprehensive assessment. Each Key to Success and Method within the campaign plan has its own specific measures of performance and measures of effectiveness linked back to a specific line of effort's objective.

Introduction

The purpose of the Metrics Annex is to explain the intent, approach and metrics developed to monitor progress toward attaining the desired end state described in the Army Medicine 2020 Campaign Plan (AM 2020 CP). Commanders must reject the tendency to measure something just because it is measurable. Effective commanders avoid burdening subordinates and staffs with overly detailed assessment and collection tasks. Generally, the echelon at which a specific operation, task, or action is conducted should be the echelon at which it is assessed. This provides a focus for assessment at each echelon. It enhances the efficiency of the overall operations process. Leaders of the organization review performance of the Campaign Plan on a cyclic basis. Performance is assessed, gaps identified, solutions debated, action plans developed, and best practices shared.

The MEDCOM Commanders' enterprise-level programming and resource allocation decisions are influenced by assessing and linking Campaign Plan metric outcomes with the common operating picture, senior leader experience, personal observations and strategic dialog between the Commander and Senior Leaders. At every occasion the following questions are asked: "Are we doing the right things? Are we doing things right? What are we missing?" The goal is to provide the Senior and Subordinate Commanders with standardized mission-enabling guidance and products, prioritized and available resources, while continuing transformation into an efficient and sustainable organization.

Metrics Approach

Purpose of Performance Management

One of the central concepts of strategy execution is that "you cannot manage what you do not measure." MEDCOM staff will use an integrated approach to performance and results tracking. The Campaign Plan review process is centered on enterprise-wide Lines of Effort. Objective within the Lines of Effort is assigned one or more programs with corresponding metrics. Sub-tasks developed for each objective describe specific actionable initiatives or programs which support the goals. The Campaign Plan metrics are used to assess changes in system behavior, capability, or operational environment related to achievement of outcomes. Most metrics are not intended to measure task accomplishment and also may not apply to every subordinate organization within the MEDCOM.

Approach to Metric Development

The Line of Effort proponent teams and program managers drive the metrics development process. The metrics are screened and selected based on their ability to capture performance efficiency, effectiveness, Voice of the Customer, and compliance with Army standards. Whenever a metric is proposed, leaders are challenged to defend why the metric matters; how much will it cost to collect the data; who needs to know; and will the metric assist with programming or resource allocation decisions? Each metric described in the Campaign Plan and in this annex is further defined and documented by the Headquarters'



metric owners on a metric definition form. This form contains a detailed Army Medicine 2020 Campaign Plan Annex: Metrics description of all data elements associated with each metric. The metrics will continue to be refined over time to improve strategic outcomes within the MEDCOM Community.

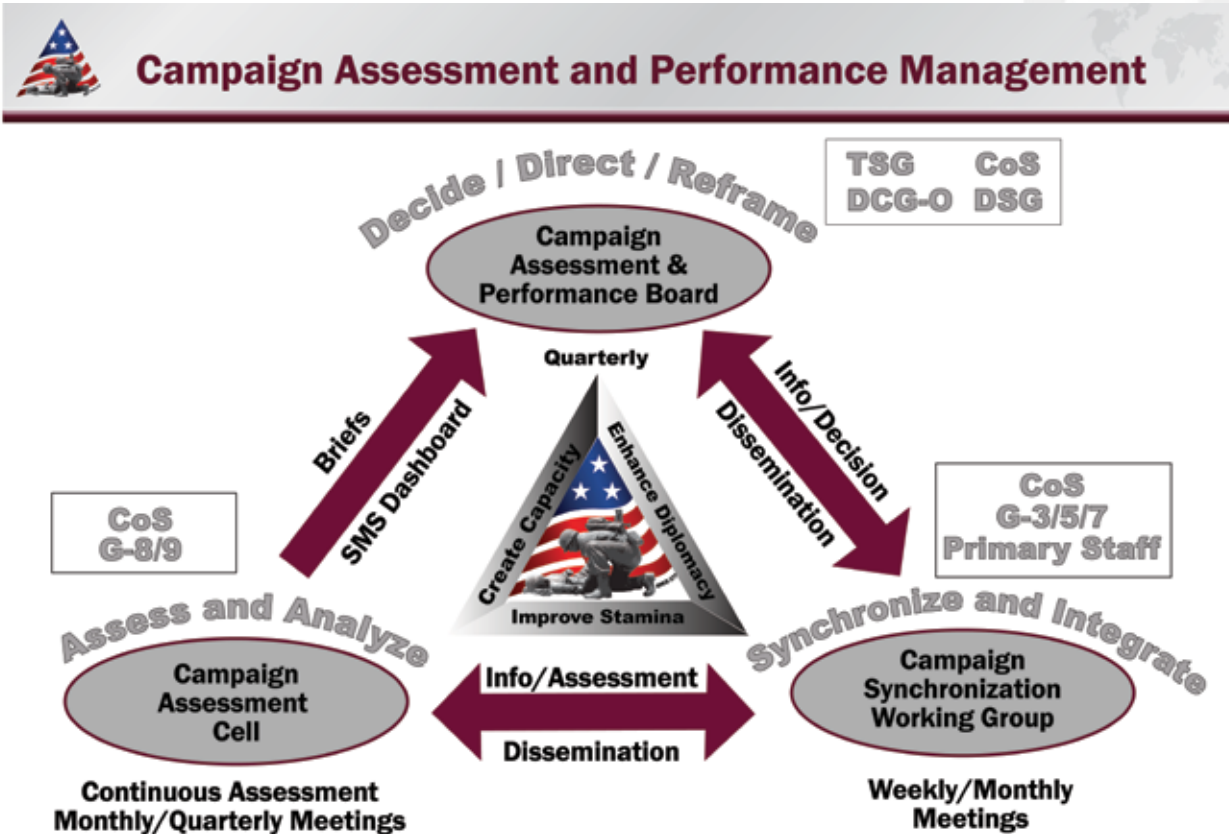
Key Elements to Metrics Deployment

The Army currently uses the Strategic Management System (SMS) as its platform to capture, align to strategy, and report performance results driven by the Army Campaign Plan. Similarly, SMS has been selected as the results reporting solution for the Army Medicine 2020 Campaign Plan. SMS is a knowledge management tool which aligns strategic focus across Regions. It is a web-enabled, data-driven, performance reporting application which is capable of capturing data from various existing sources, thus avoiding duplicate data entry. It provides a flexible, multi-tiered, enterprise wide view of performance to enable informed decisions at executive and tactical levels. The dashboard supports the Commander's desire to enter the operation center at any time and assess current performance. Detailed metric information, such as data elements, metric formulas, thresholds of performance, and source of data, is loaded into in this web-enabled application by the Campaign Assessment Cell staff. The intent is to minimize additional data collection and manual input at the installation level by pulling data from existing data collection systems when possible. There are no plans to replace existing databases. SMS has the capability to link to and automate the input of information from data sources like the Installation Status Report and Unit Status Report.

Analysis of changing health behaviors is very challenging, due in part to the need to understand perceptions and culture, the need to track hundreds or thousands of personalities, the local nature of the environment, and the tendency of environments change over time. To measure progress at the strategic level, there must be data collected not just at the strategic level but, also at the local, tactical level where individuals are most active. These measures help planners understand the operational environment to frame the problem and develop operational approaches.

Assessments occur from the highest levels of strategic planning in determining the Commander's mission areas to the evaluation of a tactical mission in a larger campaign. All assessments provide information to the command for input in the decision-making process and start during the planning process. Specifically, one of the purposes for developing an operational approach is to develop the assessments for the campaign. The measures developed aid in answering performance and effectiveness questions for the commander in reaching the desired end state. During an operation or campaign, the assessment process is a continuous operation that coincides with the decision-making process.

Campaign Assessment and Performance Management Process



Campaign Assessment and Performance Board (CAP-B)

Campaign Assessment and Performance Board (CAP-B) is the senior leader level decision and guidance making authority for assessment and evaluation of strategic level Army Medicine programs. The CAP-B has a dedicated structure, tasks, and battle rhythm.

CAP-B Structure:

- Chair: TSG
- Attendees: DSG, CoS, MSC/DRU as required, Primary Staff
- Inputs (include but are not limited to): Aggregated Measures of Effectiveness (MoE) from Assessment Cell, Issues for decision and or situational awareness from Campaign Synchronization Work Group
- Outputs (include but are not limited to): Guidance, Decision on Campaign Plan priorities, Change in resourcing, Re-framing, Tasks to Senior Plans Board

CAP-B Tasks:

- Oversee Campaign Assessment
- Measure progress with regard to outcomes
- Provides refined guidance and decisions
- Provides recommendations made to near term changes on priorities
- Review operational priorities
- Receive decision or information briefs

CAP-B Frequency: Quarterly



Campaign Synchronization Work Group (CSWG)

Campaign Synchronization Work Group (CSWG) is the ONESTAFF-level review, assessment and evaluations of strategic level Army Medicine programs and provides recommendations to the CAP-B. The CSWG has a dedicated structure, tasks, and battle rhythm.

CSWG Structure:

- Chair: CoS
- Proponent: G-3/5/7 G-33 Current Operations (CUOPs)
- Attendees: Primary Staff
- Inputs:
 - Campaign Plan Synchronization Board results
 - Status of MEDCOM Programs and Projects
 - Orders and directives from higher headquarters
- Outputs:
 - Recommends changes to priorities and resource allocation
 - Recommends priority of Planning Team effort
 - Receives or provides Plan, Order, MDMP or Design Product for Approval at Senior Plans Meeting

CSWG Key Tasks:

- Enable the leadership to make decisions on the allocation and synchronization of key MEDCOM resources required to accomplish the Commander's operational objectives
- Supports MEDCOM planning efforts through review of ongoing resource allocation and assessment against emerging MEDCOM tasks and missions
- Provides injects (Blank Task Enabler Matrix, previous SWG products, current operational priorities, current weekly assessment) into the mission analysis, course of action development, and course of action analysis phases of the MDMP
- Working group briefing identifies unresolved resource conflicts and recommends changes to priority or allocation of key Corps resources, risk/mitigation, way ahead and any command emphasis that is required to de-conflict on-going and emerging tasks and missions for decision

CSWG Frequency: Monthly CUOPs meetings

Campaign Assessment Cell

The Campaign Assessment Cell is a cross-functional, action officer body, led by the G8/9 Plans Assessments and Evaluation (PAE) and Directorate of Strategy Management (DSM) Branch to continuously monitor data collection, focus resources on CG Priorities, challenge key assumptions, recommend adaptations and prepare in progress review (IPR) progress reports for the Quarterly Assessment to the Campaign Assessment Board. All progress reports and recommendations for adaptation will be staffed through the Campaign Synchronization Working Group (CSWG) prior to the Quarterly Assessment IPR. The Quarterly Assessment IPR is a review of Campaign Plan progress given to the Commanding General.

Campaign Plan Assessment Cell Assessment Processes

1. Identifies, prioritizes and consolidates existing metrics and collection processes
2. Develops new metrics as needed



3. Ensures process includes continued reassessments and process improvement
4. Tracks performance within Strategic Management System (SMS)
5. Creates a portal to collect reports/raw data and aggregate data to identify trends and leverages process to identify best practices
6. Ensures programs and services utilize outcome measurements to inform programmatic decisions.
7. Programs and services utilize outcome data (Measures of Effectiveness) to evolve their programs in order to improve the health, readiness and resilience in the total force.
8. Ensures that capabilities will be evaluated using specific, objective, and standardized performance metrics (scorecard).
9. Ensures that continuous process improvement is utilized as the management process to ensure programs and portfolios continuously evolves to meet customer requirements.
10. Establishes a research/study capability that informs the governance process and improves the design, delivery, efficiency, and effectiveness of programs impacting health, readiness and resilience.

Campaign Assessment Cell Structure

- Chair: CoS (DCG-O interim)
- Execution: G-8/9, DSM, PAE DSC
- Inputs:
 - Data sources that populate Strategic Management System (SMS)
 - Staff/DRU/MSA Assessments
- Outputs:
 - Analysis of Measures of Performance (MoP) and Measures of Effectiveness (MoE) indicators
 - Impact on objective measures & campaign plan outcomes
 - Brief Campaign Plan Synchronization Board

Campaign Assessment Cell Key Tasks:

- Develop assessment dashboards in support of the Commander's Decision Cycle
- Assist in the development, production and assessment of the Campaign Plan
- Continuously monitor and evaluate the Campaign, and provide recommendations to the Commander
- Measure objectives quantitatively and qualitatively to provide the Commander a picture of how well the MEDCOM is accomplishing the mission
- Assist planners in the development of measurable objectives and conditions that are used to determine the success of the Campaign Plan

Campaign Assessment Cell Frequency: Monthly / Quarterly



Campaign Assessment and Performance Lead Action Officers



Campaign Design Assessment Leads

LOE 1 - Create Capacity

CO 1-1

CO 1-2

CO 1-3

DCS, G-3/5/7

ADCS, HCD

ADCS, PA&E

ADCS, PCI

LOE 2 - Enhance Diplomacy

CO 2-1

CO 2-2

CO 2-3

DCS, G-1/4/6

DCOMM

ADCS, HR

EXEC SVSs

LOE 3 - Improve Stamina

CO 3-1

CO 3-2

CO 3-3

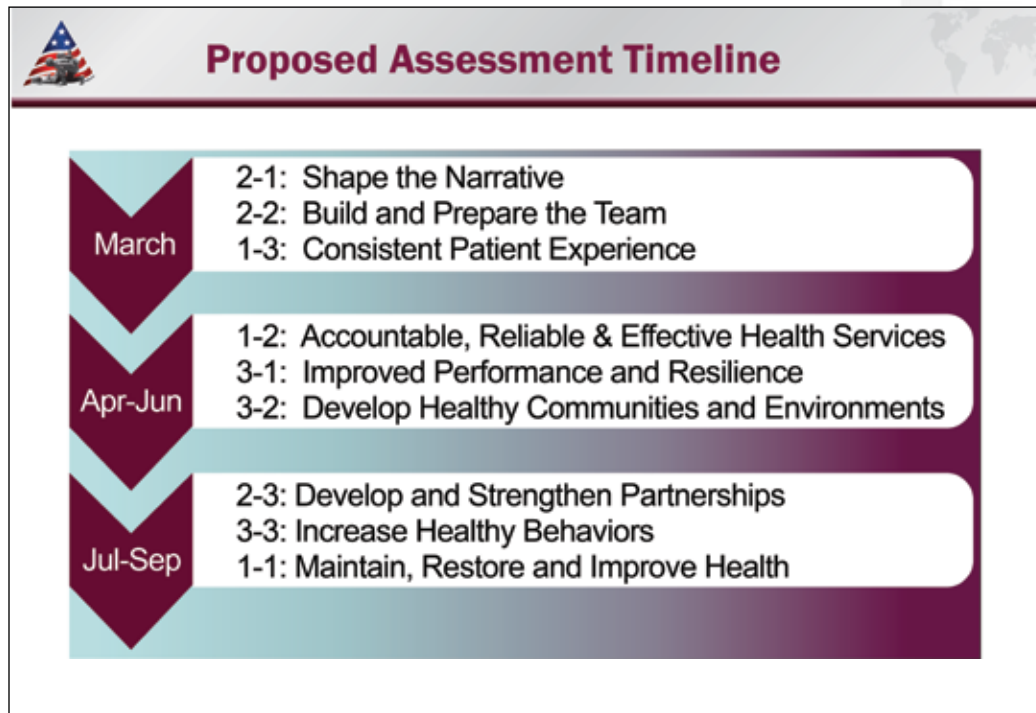
DCG, OPS

Performance Triad

ADCS, H&W

HFPA

Campaign Assessment and Performance Timeline (Initial)



Conclusion

Our outcome for driving execution of the Campaign Plan and assessing results through metrics is to improve the delivery of our services, programs to a complex set of customers who are themselves performing in a dynamic operating environment. Our end state is readiness and well-being for every person living, working, and utilizing services. By selecting and tracking relevant measures, we will enhance our ability to answer the three fundamental questions: Are we doing the right things? Are we doing things right? What are we missing?



Annex E - Communication Plan

References

1. Army Medicine Strategy 2020 (Aug 2012)
2. Army Medicine Strategy 2020 Program Efforts and Initiatives (v. 6)

1. Purpose

This is a call to action that contains the vision, strategic imperatives and way ahead for Army Medicine. It provides the strategic framework for transforming Army Medicine from a healthcare system to a System For Health and will allow Army Medicine to be a global leader in healthcare and in health.

2. Background

Throughout the last 10 years Army Medicine has focused on supporting an Army at war in two simultaneous theaters of conflict. It has improved training, modified processes, eliminated non-essential missions, and made significant contributions to global healthcare, medical research and training. But now, with the end of those conflicts in sight, Army Medicine must look forward and chart a new course that will support the strategic reset of the Army, increase Soldier readiness, improve the health of all of its beneficiaries, and ensure that medical diplomacy is a strategic Army asset. In the face of certain budget constraints, this transformation is critical to ensure Army Medicine continues to set the example for the Army, DoD and the nation in quality healthcare, prevention and collective health. The Surgeon General's vision for Army Medicine (reference 1) continues our mission to care for Soldiers, Families and Retirees, but broadens that mission to engage all patients in multiple ways to influence health in their Lifespace. Guiding and encouraging patients to make healthier choices when not under our care will increase the Army's medical readiness and improve patient health outcomes.

This new AMEDD 2020 Strategy provides strategic guidance on how Army Medicine will move from a healthcare system to a System For Health. Reference 2 outlines 35 programs and initiatives that cut across all facets of the Command to have the greatest impact on this effort, to include the Women's Health Task Force; Army Wellness Centers; behavioral health system of care; Patient Centered Medical Home; medical research; and resourcing. A key priority area within these initiatives is the Performance Triad, which focuses on Activity, Nutrition and Sleep (ANS) -- the three areas that will have the most positive impact on Soldier readiness and patient health. While all 35 programs/initiatives represent distinct efforts championed by different Army Medicine SMEs, they are all woven together to support Army Medicine's path to health, the Army's over-arching Campaign Plan (Major Objective 2-7, "Ensure that Medical Systems Support the Army."), and OSD's Quadruple Aim (Readiness, Population Health, Experience of Care, and Per Capita Cost). Communications efforts, therefore, should maintain a strategic approach on TSG's vision as discussed in the Army Medicine 2020 Strategy, while simultaneously integrating operational messages on specific programs/ initiatives, as appropriate, and aligning with the Army's over-arching Campaign Plan, and OSD's Quadruple Aim.

Three focus areas within Army Medicine have been identified as critical factors in achieving TSG's vision as outlined in the Army Medicine 2020 Strategy: Create capacity, Enhance diplomacy and Improve health (talking points for each included in pg. 11).

Create Capacity – Army Medicine's collective ability to develop the capabilities and core competencies necessary to deliver services and programs that improve healthcare, influence overall health, and make Army



Medicine a strategic enabler for the Army in the future environment. This includes optimization, innovation and organizational learning.

Enhance Diplomacy - participating and shaping dialogue on healthcare delivery and individual health in the Army, DoD, national and international communities in order to build federal, national and international enduring relationships that use medical diplomacy to advance Army values, interests and objectives.

Improve Stamina - Increase organizational depth, resiliency and endurance in order to withstand periods of intense change and unexpected challenges, and ensure that the Army Medicine System for Health is sustainable over the long-term.

While messages are a key component of this communication plan, two-way discussions between Army spokespersons and key audiences should be standard operating procedure so that Army Medicine can help defuse unnecessary concerns; identify and clarify potential misunderstandings/ misperceptions; and partner with audiences to ensure patient needs are integrated into future communications. An evidence-based communication approach is reflected in new Communication Principles (listed on pg. Annex F-8) that will help achieve the goals of the Army Medicine 2020 Strategy and strengthen audience trust and confidence in the Army Medicine's commitment to patient health.

Structure, Process and Culture

1. Structure – Army Medicine will redesign to meet the demands of the 21st Century. This will include a change in the staff of Office of the Surgeon General, Army Medical Command Headquarters and Regional Medical Commands. This change will provide The Surgeon General and the Commanding General of U.S. Army Medical Command (CG USAMEDCOM) with an integrated organization capable of seamlessly supporting all the requirements of the OTSG and HQ USAMEDCOM roles, functions and responsibilities as well as a standard template at the Regional Medical Command to execute mission command. OTSG Staff will also be realigned to better align functions with the ARSTAF, promoting harmony and fostering communication with ARSTAF counterparts.

This restructured design will also better position CG, USAMEDCOM to execute the management control program.

2. Process - The process to move from a “healthcare system” to a “System For Health” requires Army Medicine to impact the determinants of health – those lifestyle choices, social and environmental factors that contribute to overall health – that are at the heart of Lifespace.

3. Culture -The third and final major focus area is transforming the culture of Army Medicine. The AMEDD 2020 Strategy will incorporate and broaden three standing programs – **Culture of Trust, Patient Care Touch System and, finally, most importantly, a Patient-Focused Approach To Health.**

Culture of Trust - The Culture of Trust was initiated in the AMEDD in 2011. This program will be expanded and modified over the next seven years to touch all aspects of the AMEDD – the Operating and Generating Force, Human Resources and AMEDD Recruiting, AMEDD Center and School and our OES and NCOES programs and all of the other commands and functions of the AMEDD. The overarching principle is to cultivate a culture that values and extends trust throughout all facets of Army Medicine, creating a lifestyle of trust focused on the tenets of technical competency, professional excellence and excellence of others.



The Patient Care Touch System – Ensures quality care is delivered, with compassion and in accordance with the standards for best practice. The Patient Caring Touch System is comprised of five elements, which guide, gauge and ground patient centered care. These elements include Patient Advocacy, Enhanced Care Team Communication, Clinical Capability Building, Evidence-Based Practices and Health Work Environments. The Patient Caring Touch System provides sustainable framework for our transition from a health system to a System For Health.

Patient Focused Approach to Health - This is the cornerstone of our change in culture. One of the key initiatives of the MHS, the AMEDD is leading the way and expanding this to include Soldier centered care in our deployable formations. By making the patient and Soldier the “center of care,” we will ensure a system of health as well as meeting the CSA priorities of sustaining our high-quality All-Volunteer Army and providing ready forces. The strength of our Army is our Soldiers, and the Strength of our Soldiers is our Families. They must be the primary focus of our health delivery and our transformation to a system of health.

3. Desired Outcomes

Ensure key stakeholders, Senior Army Leaders, Soldiers, Family members and other beneficiaries understand and are confident that Army Medicine is committed to setting the example for the nation in quality healthcare for all those entrusted to its care.

4. Target Audiences

- Army Senior Leaders
- Soldiers
- Family Members
- Former Army leaders
- DA Civilians
- Retirees
- Congress
- Sister Services
- Civilian Healthcare Organizations
- Veterans/Military Service Organizations (VSOs/MSOs)

5. Theme

“Transformation to a System for Health”

5. Key Messages

Healthcare in the United States is at a turning point, and Army Medicine has an opportunity to lead the nation away from the status quo and improve patient outcomes and Army readiness. While the wounds of war have been and will continue to be ours to mend and heal, Army Medicine must now look forward to transform from a healthcare system to a System For Health.

- Increases in average BMI and a trend toward a more sedentary lifestyle indicate that the health of our nation is worsening.
- The United States consistently ranks below other major developed countries in the World Healthcare Organizations healthcare rankings.
- Advances in technology not only provide promise for improving the efficacy and delivery methods of healthcare, but new methods of communication will redefine how Army Medicine connects with one



another, with its partners and its patients. Increased data collection and analysis provide new opportunities for intervention and understanding.

Army Medicine priorities must align with the Army Campaign Plan, and the MHS strategy and priorities expressed by the Assistant Secretary of Defense for Health Affairs, which are both changing.

- Army Medicine will support the Army as it transitions from continuous support of persistent conflicts to a peacetime setting which requires a strategic reset of the military.
- The OSD has also announced that in the future, our nation's military will focus less on Europe and more on the Pacific. Army Medicine must consider how we must reorient to support these shifts while continuing to care for the wounds from the current wars which will exist for years to come.

Perhaps the most dominant force impacting Army Medicine is economic constraints brought about by the global financial crisis.

- Economic concerns will dominate national and international decision making for the foreseeable future, and will have a significant impact on DoD, the Army and Army Medicine.
- Escalating health care costs --which are projected to make up 20% of GDP by 2020, are viewed as unsustainable.
- The cost of our fragmented healthcare system is unsustainable, and the value that we get for our health-care dollar is inadequate.
- The recent Supreme Court decision upholding the Accountable Care Act has healthcare organizations assessing the second and third order consequences of this major health care reform while they are implementing the regulatory changes.

Army Medicine will consistently deliver evidenced-based value added services to its beneficiaries, improve existing healthcare programs and services, and develop new processes and initiatives to improve the health of the populations entrusted to its care.

Army Medicine will set the example for the nation by engaging people where they live, work, and play (i.e., the Lifespace) in addition to traditional patient care settings to improve patient health and Army readiness.

- Our System for Health will maintain fitness and health through illness and injury prevention and restore health through robust and proactive patient centered care to minimize the burden of illness and injury, and improve and prolong our lives through empowered wise choices in the Lifespace.
- Of the 525,600 minutes in a year, a Soldier or beneficiary interacts with their health care provider for an average of 100 minutes which equates to approximately 5 visits per year.
- Through engagement in the "Lifespace", Army Medicine will make the biggest impact on health. Lifespace is the time in-between doctor visits, in the thousands of minutes we're at work, or at home with our Families, where the choices are made that impact our lives every day.

The Army Medicine 2020 Strategy will improve patient health and Army readiness by creating capacity; enhancing diplomacy and improving stamina.

Create Capacity

- Creating capacity is about increasing the ability to influence health and readiness.
- It includes the delivery of healthcare and the development of new methods to impact beneficiaries' Lifespace, ground-breaking research and innovative training and education, and the global reset of healthcare forces to support the Army's and the nation's strategic defense priorities.



- However, building capacity is not about simply doing more, it is about doing things better. In a fiscally constrained environment building more facilities or hiring more people is not tenable.
- Army Medicine must innovate, learn and grow as an organization.
- Army Medicine must use its existing resources and proliferation of knowledge management to create value for its beneficiaries and the Army.
- Army Medicine must rely on evidenced-based practices to deliver efficacious services to its patients in a consistent manner. By doing this Army Medicine can eliminate unnecessary services and create capacity for new modes of care and intervention.
- Army Medicine has been maintaining, restoring and improving health for 237 years; this is its mandate.
- Like other national healthcare systems, Army Medicine has focused more on restoring health and treating patients when there is a problem rather than maintaining and improving their overall health status and reducing the need for restorative care.
- To get from healthcare to health, Army Medicine must refine its abilities and increase its reach.
- Maintaining Health, Restoring Health, Improving Health – MRI – these are Army Medicine’s major of lines of effort for creating capacity.

Enhance Diplomacy

- The responsibility for diplomacy runs through all levels of Army Medicine.
- From the combat medic at the tip of the spear, who provides first line care to Soldiers and represents Army Medicine to the line, to those engaging with internal and external stakeholders in a variety of forums, we all have a role in diplomacy.
- Army Medicine will enhance diplomacy by participating in and shaping dialogue on healthcare delivery and individual health in the Army, DoD, national and international communities.
- Diplomacy consists of three facets: Partnering, Active Engagements, and Outreach/ Marketing Initiatives.
 - Partnering: Every member of the Army Medicine team is critical to diplomacy. Army Medicine must partner internally and externally to enhance communication, collaboration, and innovation; all of which will ensure long-term sustainability of Army Medicine and advance the Army agenda.
 - Active Engagements/Outreach Initiatives: Through proactive internal and external engagements Army Medicine will speak with “One Voice” and provide a clear, concise, and consistent message. This message will also be reflected in outreach/ marketing initiatives and communication products that get everyone on the same page and ensure consistency in strategic messaging and communications.

Improve Stamina

- Stamina is the ability to expend effort over time. Increased stamina not only makes prolonged activity more sustainable but also facilitates short bursts of activity when unforeseen challenges arise.
- Army Medicine must increase both organizational and individual stamina to withstand this intense of period of transformation from a healthcare system to a System For Health, and then sustain the System For Health for years to come.
- When speaking of organizational stamina, the focus is on ensuring long-term sustainability for Army Medicine, looking over the horizon at the “next generation” of healthcare and health delivery.
- Organizational stamina is built by improving and refining Army Medicine infrastructure, training, leader development, knowledge sharing, and ability to innovate.
- At the individual level, improved health and resilience translate into improved stamina.
- The World Health Organization (WHO) defines Health as the “complete physical, mental and social well being, and not merely the absence of disease or infirmity.”
- Health is an integral component of readiness. Army Medicine and Army Leaders must better prepare



our Soldiers and their Families to negotiate the health risks facing them every day.

- Army Medicine must look for opportunities to educate and influence the health of its patients, starting with the basics of activity, nutrition and sleep. Army Medicine's operational approach to improve Soldier and Family health and stamina will focus upon Activity, Nutrition, and Sleep Management (ANS).

Army Medicine Communication Plan Principles

Army Medicine communication is science-based, timely, accurate, honest, transparent, compassionate, respectful, open-minded, credible and consistent.

Army Medicine communication is never condescending or paternalistic toward others.

Army Medicine communication is transparent so that all interested audiences can make informed decisions about their health and safety.

Army Medicine communication is accountable so that all interested audiences can observe our commitment in action.

Army Medicine communication adopts a two-way, collaborative approach to message/ information development so that the needs, perceptions, and expectations of audiences can be identified and addressed effectively.

Army Medicine communication respects differing viewpoints and embraces the peer-review process.

Army Medicine communication respects the rights of those with opposing views, and does not attack their views or motives, but vigorously and appropriately corrects factual errors and challenges misinterpretations and misjudgments.

Army Medicine adopts only ethical communication techniques, and does not rely on deception to advance its reputation, or its medical or public health recommendations.

Army Medicine communication embraces plain and simple language to eliminate potential ambiguity in its recommendations and research results.

Army Medicine communication does not withhold information or be reluctant to provide information to avoid embarrassment , increased public/ media scrutiny, or to avoid discussing uncertainty.

Army Medicine communication will balance legal requirements, when needed, with proven communication principles of transparency and honesty.

Sources:

DoD Principles of Information, 9 Nov 2001. Centers for Disease Control and Prevention, 2002



Annex F - Glossary

Army Campaign Plan (ACP): IAW ACP 2012, dated 30 May 2012, the ACP Identifies significant Army initiatives requiring Senior Leader purview and the actions required to achieve the desired end state, focused on the near- to mid-term (eight years out). The ACP and its associated Forums provide a conduit for the Senior Leaders to supervise and manage those initiatives across the Army. In that effort, the ACP directs, synchronizes and integrates HQDA planning, preparation, and helps manage the execution of these initiatives across the domains of doctrine, organization, training, material, leadership and education, personnel, and facilities (DOTMLPF) and Service Department Title 10 functions. It is informed by historical and current Program Objective Memorandum (POM) decisions, and helps inform future POMs. The ACP applies to HQDA, ACOMs, ASCCs, operational-level Army Forces, DRUs and supporting agencies and activities.

Assist: MEDCOM organizations or staff elements that provide augmentation, coordination, products, funding or other support to a Lead for a function, task, objective or role, are operating in an Assist role. Support includes, but is not limited to, all applicable Doctrine, Organization, Training, Materiel, Leadership and Education, Personnel and Facilities (DOTMLPF) domains, Core Functions and Key Enablers. Organizations that Assist, support in line with their roles, responsibilities and functions as required by a Lead organization.

Campaign Assessment and Performance Dashboard (CAP-D): An Army Medicine enterprise performance-management system (with a supporting web-based tool) that utilizes the Strategic Management System to analyze, assess, and measure progress towards objectives and endstate [See SMS].

Campaign Plan: IAW TRADOC Pam 525-5-500 , Campaign plan should be broad and conceptual. A campaign plan must explain the problem(s) to be solved and the framework of the campaign design. Therefore, the planning horizon of a campaign plan must extend to the end of the campaign. Detailed lower level operational and tactical directives must nest within the design of the campaign plan. Those orders and plans focus on implementation and have a closer planning horizon.

The probable duration of a campaign makes reframing a certainty. Therefore, a campaign plan cannot be a thick and unwieldy tome. Campaign plans must be brief, succinct, clear, and easy for high-level executives to read. Senior leaders must read it and planners must be able to nimbly republish the plan with a modified framing of the problem and/or design of the campaign when reframing makes these adjustments necessary.

Decisive Point: A geographic place, specific key event, critical factor, or function that, when acted upon, allows commanders to gain a marked advantage over an adversary or contribute materially to achieving success. (JP 3-0)

End State: (DoD) The set of required conditions that defines achievement of the commander's objectives. See ADRP 3-0

Focus Area: Program(s) within a given campaign objective that have been identified as areas of concentration or effort.

Health (According to World Health Organization, 2012):

1. Health is a state of complete physical, mental and social well being and not merely the absence of disease or infirmity (WHO Constitution, 2012).
2. The extent to which an individual or a group is able to realize aspirations and satisfy needs, and to change or cope



with the environment. Health is a resource for everyday life, not the objective of living; it is a positive concept, emphasizing social and personal resources as well as physical capabilities (Health Promotion: A Discussion Document, Copenhagen: WHO 1984).

3. A state characterized by anatomic, physiologic and psychological integrity; ability to perform personally valued Family, work and community roles; ability to deal with physical, biologic, psychological and social stress a feeling of well-being; and freedom from the risk of disease and untimely death (J. Stokes et al. "Definition of terms and concepts applicable to clinical preventive medicine", J Common Health, 1982; 8:33-41).
4. A state of equilibrium between humans and the physical, biologic and social environment, compatible with full functional activity (JM. Last, Public Health and Human Ecology, 2nd ed. Stamford, CT: Appleton and Lange, 1997).

<http://www.who.int/hac/about/definitions/en/>

Health System: (i) all the activities whose primary purpose is to promote, restore and/or maintain health; (ii) the people, institutions and resources, arranged together in accordance with established policies, to improve the health of the population they serve, while responding to people's legitimate expectations and protecting them against the cost of ill-health through a variety of activities whose primary intent is to improve health. (World Health Organization, 2012)

http://www.who.int/healthsystems/hss_glossary/en/index5.html

Key Task: Those activities the force must perform as a whole to achieve the desired end state. (ADRP 5-0)

Lead: Leads have primary responsibility for a task, objective, function or role, from task or objective assignment, through development of plans, and monitoring of progress until completion. A Lead can be assigned for an MO, a SubTask, or any level of Supporting Tasks. Task Leads coordinate with MEDCOM Staff elements, Major Subordinate Organizations and organizations responsible for MEDCOM Core Functions and Key Enablers to ensure horizontal and vertical integration one level down in all aspects of planning and execution. A Task Lead at any level is responsible for seeking assistance from other organizations or staff elements as needed and is responsible for ensuring any assisting organization understands the assistance requirements. MO Leads brief MO status at MEDCOM Synchronization Meetings (TSMs) and are responsible for coordinating the statuses of each of the SubTasks.

Line of Effort (LOE): A line of effort (LOE) is a line that links multiple tasks using the logic of purpose rather than geographical reference to focus efforts toward establishing operational and strategic conditions (ADRP 3-0). LOE are used to accomplish specific Major Objectives leading toward desired conditions and an end state.

Lifespace: About one-third of life is spent working, another third with Family and friends and another third sleeping. Providers see patients on average about 100 minutes out of 525,600 minutes. Health occurs in the Lifespace, or in other words, the 525,500 minutes spent away from the doctor's office.

Major Objectives: Major Objectives (MOs) are mid-long term (2-7 years) efforts that are necessary to collectively achieve the MEDCOM Commander's vision and end state. MOs are clearly defined, attainable goals with measurable outcomes. The Army Campaign Plan (ACP) and the Military Health System (MHS) strategic guidance sources for the development of MEDCOM's MOs. Concomitant with this; MEDCOM's MOs are nested within the ACP work currently underway. Each TSP MO is nested within one of the three MEDCOM LOEs. Major Objectives are accomplished through the development and execution of their nested SubTasks, Supporting Tasks and the associated Milestones, Decision Points and resourcing plans and are managed in terms of the TSP's Time Horizons. Finally, all MOs are supported in planning and execution by the MEDCOM Key Enablers.



Operating Company Model: The Operating Company Model (OCM) is an organizational methodology that will enable Army Medicine to move toward a System For Health. The OCM framework is designed around integrated, standard processes across the organization; performance metrics and decision-making that are clearly defined for these processes, thereby driving accountability; and a high focus and priority given to process quality, repeatability, and standards to drive a better, more consistent patient experience while also containing costs.

The OCM framework, with its five critical components, will drive consistency, clarity and accountability across the Lines of Effort (LOEs). The OCM translates strategy into operational capabilities, and as a result provides the foundation for execution. These components are:

1. *Process Structure:* Development of repeatable processes with clear standards and owners, and line of sight to integration points. This will answer: How does Army Medicine get things done with high quality?
2. *Organizational Structure:* Creation of an organizational structure that supports the business processes and outlines roles, responsibilities and reporting lines. This will answer: How do we deploy our people in support of our LOEs?
3. *Governance and Decision-making:* Development of a governance structure that clearly delineates decision-making authority and accountability. This will answer: Who makes the call when we have competing priorities?
4. *Performance Metrics and Accountability:* Implementation of a performance management system inclusive of metrics, benefits realization for resource and budget consumption, and a continuous improvement mechanism. This will answer: How well we are performing and communicating results?
5. *Culture:* Embracing an interdependent, transparent and collaborative relationship across Army Medicine functions/services reinforced through a system of accountability. This will answer: How well we work together to support the LOEs?

Outcome: Something that happens as a result of an activity or process: RESULT (Merriam-Webster Dictionary 2012)

Performance Triad: The Performance Triad is composed of Activity, Nutrition and Sleep (ANS), and is foundational to Army Medicine's transformation to a System For Health.

Portfolio: A group of projects that are being worked on at the same time.

Portfolio Management: The management of a number of projects that do not share a common objective.

Program: A group of related projects that are managed together. Programs usually include an element of on-going activity. Programs are managed by program managers or program directors who manage the work of the individual project managers.

Project: A temporary endeavor undertaken to create a unique product or service. Any undertaking with a defined starting point and defined objectives by which completion is identified. In practice most projects depend on finite or limited resources by which the objectives are to be accomplished.

Project Portfolio: An organization's group of projects and the process in which they are selected and managed. The project portfolio is strategically selected to advance the organizational goals to reach a desired end state.



Ready and Resilient Campaign (R2C) Plan: The HQDA Ready and Resilient Campaign is designed to guide the Army's efforts in building and maintaining resilience across the Total Army- Soldiers, Family Members, and Army Civilians, improving unit readiness, and further reinforcing the Army Profession. The campaign requires unity of effort and command emphasis to accomplish these primary goals. There is also an implicit cultural change associated with the campaign that emphasizes the importance of resilience to our sustained readiness in the future. The Ready and Resilient Campaign shapes the Army by:

- Changing the way the Army manages, organizes, and coordinates Army programs and services affecting Soldier, Soldier Family Member, and Army Civilian resilience, beginning with the creation of a governance structure at the Headquarters Department of the Army-level down to installation/regional-level coordination councils that align efforts to deal with complex issues. This will improve the effectiveness of the programs and services and ensure comprehensive care, both preventive care and treatment, is available to the Total Force.
- Incorporating resilience as a critical component in determining Soldier and unit readiness, emphasizing the importance of physical, psychological, and emotional factors in determining comprehensive fitness, and promoting a deliberate approach to building and sustaining resilience.
- Emphasizing leadership responsibility at every echelon. Commanders are ultimately responsible for Soldier resilience and unit readiness. Leaders at all levels must understand that high standards of professionalism and discipline represent readiness within their formations. The campaign reinforces leadership at the first line supervisor-level. Leaders are empowered and enabled to enforce standards of professionalism and discipline, and they are held accountable for maintaining and improving resilience and readiness within their formations. Individuals must also be accountable for building and sustaining their personal resilience and readiness.
- Finally, creating a common understanding of resilience and its benefits, as well as the mindset required to make resilience an enduring part of our professional culture. Ultimately, the goal is for our actions and deeds to speak louder than our words to our Soldiers, Families, Army Civilians, and external audiences.

The Ready and Resilient Campaign is comprehensive in addressing the immediate and enduring needs for Active, Reserve, and National Guard Soldiers, our Families, and Army Civilians. The Ready and Resilient Campaign Execution Order (EXORD) will follow-up behind the Campaign Plan with specific tasks and details for the execution of the campaign (HQDA Ready and Resilient Campaign Plan – Draft v19, December 2012).

Resilient: Resilience is the mental, physical, emotional, and behavioral ability to face and cope with adversity, adapt to change, recover, learn, and grow from temporary setbacks (HQDA Ready and Resilient Campaign Plan – Draft v19, December 2012).

Service Line (SL): A collaborative core team focused on a major AMEDD health domain with full visibility of assets, policies, services and resources. The team will incorporate key stakeholders to assess domain performance, set policy, and build a collaborative enterprise community of practice. This includes the spectrum of health from promotion, maintenance, restoration and improvement utilizing the operating company model as the foundation to ensure consistency, clarity, and accountability. The Service Line will provide evidence based tools to equip RMC and Medical Treatment Facility commanders for mission success.



Also:

Service Line (SL): A selection of clinical activities organized around a diagnosis to provide a patient highly coordinated care and a single point of access. Service Lines vary their structure across organizations to meet their specific needs; however, in general a SL has centralized control, standard processes, protocols, and metrics and is organized to optimize care coordination at all points of care locations (Ernst & Young Best Practice Report on Service Lines).

- **Service Line Management (SLM):** Brings decision-making and accountability to frontline clinicians. Each service line is treated as a business unit responsible for the quality of patient care, patient satisfaction, staff productivity, and financial performance (Ernst & Young Best Practice Report on Service Lines).
- **Strategic Staff Management:** Strategic Staff Management requires a staff section to serve as the integrating higher headquarters staff to coordinate with Leads in order to provide a consolidated MEDCOM position, product or policy. Staff Management ensures tasks are horizontally and vertically integrated and that a coordinated position in line with Commanding General (CG) MEDCOM's intent is presented. Staff Managers support Leads through their analysis, assessment, coordination, and development of recommendations for the MEDCOM Command Group, and should anticipate providing interface / liaison with external agencies on behalf of Leads. Staff Managers facilitate the coordination and cross-fertilization of plans, doctrine, products, and policy with higher HQ and external agencies, as appropriate, to reach a level of integration Leads might not otherwise attain. At TSMs and ACP events, in support of the MO and Sub-Task Leads, Staff Managers should anticipate providing integrated insights, notes pages, or information as needed.
- **Strategic Management System:** As an enterprise performance-management framework (with a supporting web-based system), SMS aggregates key performance indicators from all functional levels of the Army and delivers strategically focused presentations to the Army's executive leaders and all subordinate command levels. It is accessible to anyone with an Army Knowledge Online (AKO) account and a computer (after SMS access is granted). SMS uses a hierarchical structure based on overarching strategies, strategic initiatives, tasks, and metrics.

SMS provides a cross-functional snapshot of the Army's strategic posture in a top-down, data-driven, performance-metric format. This automated tool facilitates an enterprise-level approach to Army decision-making and strategy management and serves as an enabler to bring the Army back in balance.
- **Sub-Tasks:** Clearly defined, measurable, and quantifiable statements of work to be done. They are the result of a deliberative process where the MO Leads plan the development and way-ahead of specific tasks. MEDCOM Staff Managers assist MO Leads in the examination of each of the MEDCOM Core Functions (CFs) to determine how integration of the CFs supports Sub-Task execution. This is necessary to gain an understanding of required actions and activities to achieve Major Objectives' end states within the three time horizons. Sub-Tasks, when executed over the timeframe of the plan, collectively define achievement of Major Objectives. Each Sub-Task has defined and measurable Supporting Tasks, Milestones, Decision Points (DPs) and a resourcing plan. Many Army Campaign Plan tasks for which MEDCOM is lead or team member are reflected as TSP Sub-Tasks.



• **Supporting Tasks:** Measurable and quantifiable tasks which must be completed in order to accomplished a Sub-Task. Based upon mission analysis, Major Objective and SubTask Leads assign Supporting Tasks to organizations which serve as Leads and Assists as required to accomplish the SubTasks. Assigned Leads develop and mature their Supporting Tasks and identify execution in terms of the Time Horizons, Milestones, Decision Points and resourcing requirements to execute the plan. Major Objective and SubTask Leads track Supporting Task accomplishment at their levels. In some cases a Supporting Task may be of such importance that (as a critical step towards achievement of a Decision Point or in support of a critical node) it may be raised in hierarchy to the SubTask level, if only to provide visibility to the Deputy Commanding General (DCG) MEDCOM.

• **System:** A set of interacting or interdependent components forming an integrated whole. Common characteristics include: Structure, Behavior, and Interconnectivity.

• **System For Health (SFH):** ...is a partnership among Soldiers, Families, Leaders, Health Teams and Communities to promote **Readiness, Resilience and Responsibility.**

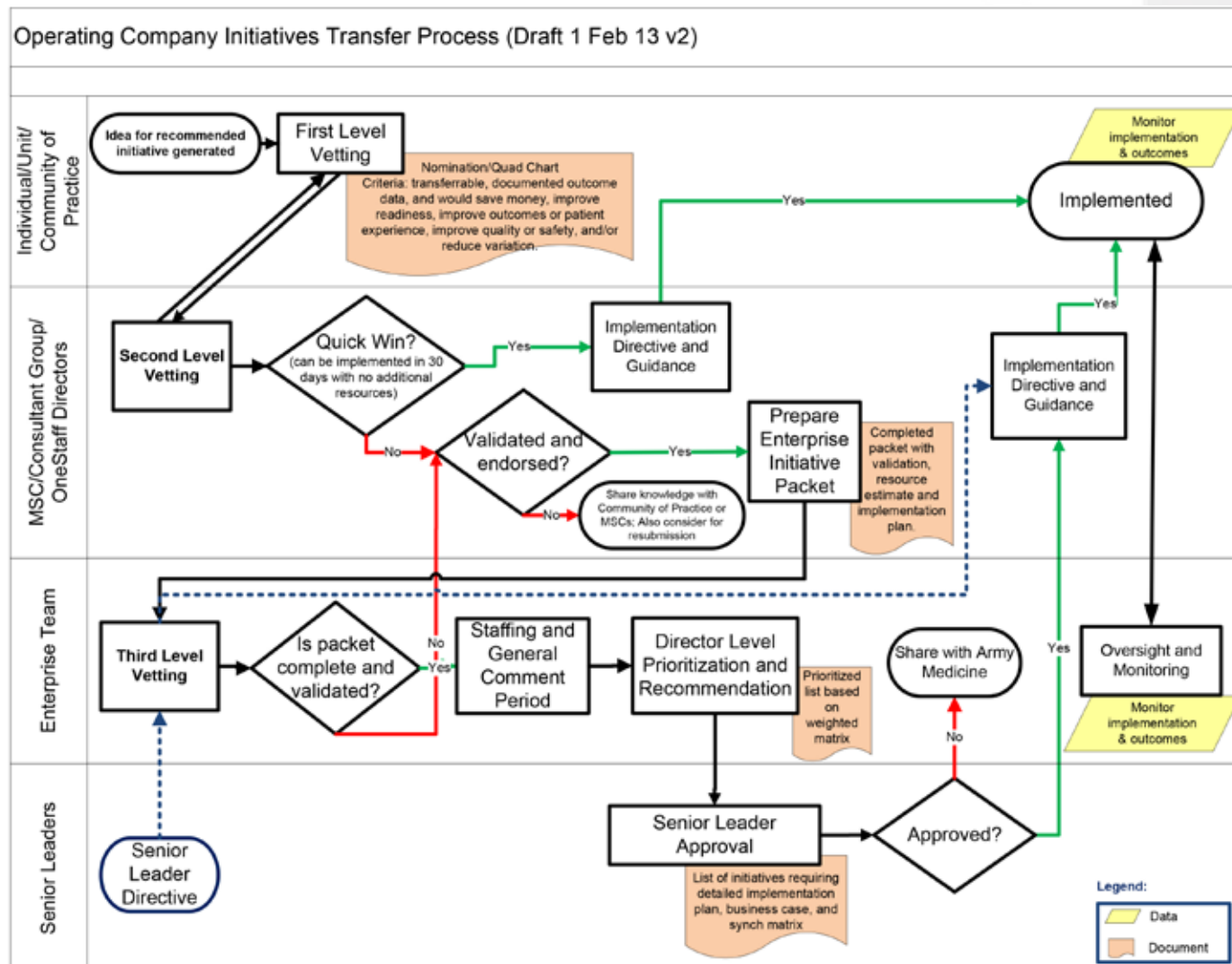
- **MAINTAINS** health through fitness and illness/injury prevention
- **RESTORES** health through patient centered care
- **IMPROVES** health through informed choices in the Lifespace



Annex G - References

1. Department of the Army Campaign Plan 2012
2. Army Strategic Planning Guidance 2012
3. US Army Ready and Resilient Campaign Plan [Draft] 2012
4. Army Medicine Strategy – The Road Ahead (v2.B as of 29 Aug 2012)
5. US Army Doctrine Comprehensive Guide 2012
6. Total Fitness for the 21st Century Conference Report Institute for Alternative Futures, December 30, 2009
7. Public Diplomacy: Strengthening U.S. Engagement with the World A strategic approach for the 21st century, Office of the Under Secretary of State for Public Diplomacy and Public Affairs, 2012
8. The Health System Assessment Approach Manual, V 1.75, USAID, May 2012
9. World Health Organization (WHO) Health 2020
10. Total Fitness Conference Report
11. World Health Statistics, Global Health Observatory 2012
12. http://www.who.int/gho/publications/world_health_statistics/en/index.html
13. TRADOC PAM 525-3-0 The US Army 2020 CAPTSONE Concept
14. Installation Management Command (IMCOM) Campaign Plan 2012-2020

Annex H - Army Medicine Best Practice Procedure



Initial Nomination/Individual or Unit Level: Individuals or units may recommend initiatives for validation and transfer/standardization across MEDCOM. The first step is ensuring the initiative has already been implemented with documented outcome data and would save money, improve readiness, improve patient outcomes or experience of care, and/or reduce complexity. The completed nomination should then be sent to the appropriate Consultant or major subordinate command (MSC) for validation at their level and endorsement as an enterprise level initiative.

Initial Validation/Consultant Group/MSC Level: Consultant Group Leaders, MSCs, and OneStaff Directors can formally nominate initiatives for Enterprise validation. However, they should first review, confirm outcomes, ensure the practice has succeeded at more than one site, prepare an implementation plan, estimate resources required, and endorse the nomination before for submitting to the OTSG/MEDCOM level.

Enterprise Validation/OTSG/MEDCOM Level: A multi-disciplinary team at the OTSG/MEDCOM level will validate the packet, prioritize initiatives, and make recommendations to senior leaders. The enterprise level will also ensure transparency of the process, monitor implementation and performance, and reward success.



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ARMY MEDICINE
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